Social Determinants Affecting The Mental Health Of HIV Infected Latino Men Who Have Sex With Men Living On The U.S. - Mexican Border

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SOCIAL DETERMINANTS OF MENTAL HEALTH AMONG LATINO MSM LIVING WITH HIV/AIDS ON THE U.S.-MEXICO BORDER.

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SOCIAL DETERMINANTS AFFECTING THE MENTAL HEALTH OF HIV INFECTED LATINO MEN WHO HAVE SEX WITH MEN LIVING ON THE U.S.-MEXICO BORDER.

By

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DISSERTATION

Presented to the Faculty of the Graduate School of
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The HIV/AIDS global pandemic is more than three decades old, and although the continual advancement of antiretroviral therapies have successfully decreased the mortality rates of people living with HIV/AIDS (PLWHA), little has been done to improve their mental health status and positive inclusion in society (eliminating discrimination and stigma). This is especially true with the Latino PLWHA living in the U.S.-Mexico border area.

This paper presents data from a qualitative study focused on exploring the mental health issues of a subsample of 40 HIV-infected Latino men who have sex with men (MSM) living on the U.S.-Mexico Border. This subsample was part of an NIH study on antiretroviral adherence on the US-Mexico Border. Data was collected using in-depth interviews that were recorded and transcribed by the research team. The coding and analysis of the emerging themes were conducted using a qualitative data analysis software.

Results show that with an increased presence of stigma and discrimination due sociocultural factors on the U.S.-Mexico border the Latino MSM living with HIV/AIDS struggle for accessing adequate behavioral medicine services. All participants reported and mentioned having a certain level of depression. The information was collected throughout the in-depth interviews and cross-validated with a self-reported depression scale (BDI-II). Only 30% of the total sample was taking medication to treat their depression; and only 7.5% of the participants who reported severe depression were being treated with antidepressants. There was an
important gap in the management and treatment of depression among the participants’ sample.

Some of the factors affecting mental health of Latino MSM living with HIV/AIDS are the participant’s socioeconomic status, job insecurity, access to healthcare, and the unique cross-border dynamics which include: commuting between the two border cities in order to access complementary healthcare services, the levels of support offered by friends and family in living on both sides of the border, and the increased border violence.
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CHAPTER 1

INTRODUCTION

The HIV epidemic is still a salient global public health issue (WHO, 2012). The most affected group by the epidemic continues to be men who have sex with men (MSM). In the U.S. racial and ethnic minority MSM are the disproportionately affected by the epidemic compared to their non-Latino white counterparts (CDC, 2012).

Different studies have addressed the importance of mental health in the self-care behaviors and treatment progression of people living with HIV/AIDS (PLWHA) (Uphold & Mkanta, 2005; Han & Liu, 2005). Clinical depression is the most common co-morbidity among PLWHA and one of the principal conditions affecting treatment progression (Simpson, Krishnan, Kunik, & Ruiz, 2007).

This proposed study focuses on exploring the phenomenon of how different social determinants of health (SDH) affect the well-being of Latino men who have sex with men living with HIV/AIDS (LMSMLHA) on the U.S.-Mexico border. The research has a particular interest in exploring the meaning of different health beliefs and health practices, and the impact that different SDH have in the stress and depression of LMSMLHA. The knowledge generated from this study will contribute to new insights that can inform healthcare professionals, academics, and students conducting research in the field. The proposed research will employ qualitative research methods following a phenomenology tradition to better understand the phenomenon of interest. Participants for this qualitative study consist of Latino MSM receiving HIV/AIDS healthcare treatment at a community-based healthcare center located in a city on the southwest U.S.-Mexico border.
1.1 Problem and Statement of Purpose

The purpose of this study was to explore the importance that different social determinants of health (such as economic issues, and social and family support) have in a group of LMSMLHA and how these may affect their physical and mental well-being. The study will also explore the meaning of health beliefs and practices influencing the health-seeking behaviors of this group.

Latinos across the United States suffer from disproportionate rates of HIV/AIDS mortality (6.9%) compared to non-Latino whites (3.5%) (CDC, 2012). In the state of Texas, while HIV/AIDS-related mortality rates decreased for African-Americans and whites from 2002 to 2008, they increased by 3 percent among Latinos (TDSHS, 2012). In 2011, El Paso County ranked 6th in all Texas Counties in total number of cases of HIV/AIDS (TDSHS, 2012).

The U.S.-Mexico border has a unique demographic distribution paired with a hybrid (mixed) culture, which does not reflect the interior of either country. The Latino population in this region comes primarily from Mexico or is of Mexican descent. Cross-border commuting is part of the daily activities of millions of habitants of the region. It is important to address the needs of the LMSMLHA population on the U.S.-Mexico border, including the El Paso region. Given the fact that there is an increasing disproportion of mortality rates among Latinos (compared to whites and African-Americans) in the state of Texas, it is especially important to concentrate research efforts in cities such as El Paso in which the Latino population accounts for 80 percent of the total population. Little is known about which social determinants of health (such as friend and family support, economic situation, and daily activities) are involved in forming the mental and physical well-being of this group. More research is needed in order to
understand the meanings that different health beliefs and practices represent for this target population.

1.2 Study Aims and Research Questions

This study aims to understand how a sample of Latino MSM living with HIV/AIDS (LMSMLHA) in the El Paso region experience different social determinants in their daily activities and how their activities relate with their mental and physical well-being. The proposed study will explore four different areas of the meanings of the participants’ life experiences: 1) the level of depression that the participant sample report; 2) the experienced social determinants affecting the participants’ level of stress; 3) the behavioral strategies these men use to reduce their stress levels; and 4) the health beliefs and practices participants reported using to maintain health.

Four research questions were proposed to help better understand the meanings of the areas of interest: 1) what is the level of depression in a sample of LMSMLHA on the U.S.-Mexico Border? 2) Which social determinants of health affect participants’ stress? 3) What are the behavioral strategies that participants use to reduce their stress levels? And 4) What are the group’s health beliefs and practices?

1.3 Assumptions

Based on the researcher’s experience with the available HIV/AIDS literature and with the background and familiarity of the culture in the border area of El Paso/Ciudad Juarez (the researcher is native from the region), the following assumptions can be made regarding the study:
First, it is assumed that depression is one of the primary factors affecting the way healthcare behaviors are adopted and effectively carried out by PLWHA. Second, it is assumed that sociocultural factors determine the beliefs which LMSMLHA have regarding health, disease, and HIV/AIDS infection as well as the practice of different activities and behaviors that the men believe help them maintain health. Finally, it is also assumed that the available social support that PLWHA receive from their family, partners, and friends affects their levels of depression and stress as well as the activities used to reduce stress.

1.4 Study Rationale and Significance

Overall, there is a significant disparity in the rates of infection among MSM versus heterosexual men across all ethnic and racial backgrounds. The MSM population suffers disparities in the healthcare system and in seeking preventive services. This is primarily due to the heterosexual cultural normativity. This disparity becomes apparent when considering the fact that MSM account for a small number of the general population but they account for more than 60 percent of the HIV/AIDS cases in the U.S. (CDC, 2011).

The rationale to conduct this research comes from a need to address the HIV/AIDS disparity that is affecting Latino MSM living in El Paso County in comparison to the other Latino men who have sex with men who live in the state of Texas. The significance of conducting this study will result in a description of different social determinants of health affecting the mental and physical well-being of infected Latino MSM living in El Paso County, as well as their health beliefs and practices. Having a better understanding about the meaning of the beliefs, practices, and social determinants of health of this population can improve the
development of new research in this area, as well as decision-making processes of healthcare workers and agencies who are working with PLWHA along the U.S.-Mexico border.

The contribution of this research to the available body of scientific literature is that 1) it is one of the few studies focusing on exploring the meanings of social determinants of health and health belief and practices of the Latino population in the U.S. and, 2) this study will be the first which target the social determinants of health among Latino MSM population living in El Paso County and the U.S.-Mexico border, and 3) it will be the first research study addressing these factors using a phenomenology approach.
CHAPTER 2
LITERATURE REVIEW

2.1 General Background and Context

This section provides information about the HIV/AIDS pandemic. Starting with statistics about the situation worldwide and finishing with statistics about the HIV/AIDS situation in the El Paso region.

2.1.1 The HIV/AIDS Pandemic

The human immunodeficiency virus (HIV) is the agent that causes the acquired immune deficiency syndrome (AIDS). This condition has affect people all over world for more than 30 years. It is estimated that about 60 million people have been infected with HIV and about 30 million have died from AIDS-related complications around the world (WHO, 2012) since the beginning of the epidemic (1981). Although HIV/AIDS has a global distribution, some regions have been disproportionately affected due to different social, economic, and political factors (Morrison, 2001).

The HIV affects CD4 + lymphocytes (a type of T-helper cell) in the body. These cells are in charge of regulating the activity of other lymphocytes and their antibody production. The destruction of CD4 + by HIV causes a faulty immune response and subsequent development of AIDS, characterized by a decreasing ability of the immune system to control opportunistic and other infections (Hamann, 2007).

The HIV was first recognized in 1981 when cases of a rare type of pneumonia (Pneumocystis jirovecii pneumonia) and skin cancer (Kaposi’s sarcoma) arose among the population of MSM (Kanki & Essex, 2000). Although 1981 was considered the beginning of the AIDS epidemic, it is believed that HIV was affecting people years before it gained mass media
attention (The Henry J. Kaiser Family Foundation [KFF], 2013). At that time, AIDS was termed Gay-Related Immunodeficiency Disease (GRID), which generated severe stigma toward the MSM population. It was not until HIV spread to different populations such as injection drug users and hemophiliacs that the name of the condition was changed to AIDS in 1982 (Merson, O'Malley, Serwadda, & Apisuk, 2007). During the first decade of the HIV/AIDS epidemic in the 1980s, there was much uncertainty about the ways AIDS was transmitted. However, it was not until 1983 that Dr. Luc Montagnier, from the Pasteur Institute and Dr. Robert Gallo, from the National Cancer Institute working separately, discovered nearly simultaneously, that the agent causing AIDS was a retrovirus that was later termed HIV (KFF, 2013). During the late 1980s, U.S. and international health authorities started disseminating preventive measures targeting specific at-risk groups such as MSM and injection drug users. During this decade, the first treatment guidelines to prevent Pneumocystis jirovecii and other opportunistic infections were published by the U.S. Centers for Disease Control and Prevention (CDC). In addition, the U.S Food and Drug Administration (FDA) approved the first antiretroviral drug (Zidovudine [AZT]) providing new hopes for people struggling with the infection. In 1985, the first International AIDS Conference took place in Atlanta, Georgia where thousands of healthcare workers gathered to learn and exchange information about HIV/AIDS (KFF, 2013).

During the first half of the 1990s, HIV became the leading cause of death among Americans 25 to 44 years old (KFF, 2013). Although not many advances were made in the treatment of HIV/AIDS during that time period, different important social events occurred. One of them happened when local and international AIDS organizations and physicians boycotted the 6th International AIDS Conference in response to the U.S. immigration policy which prohibited people diagnosed with HIV/AIDS from entering the U.S. (KFF, 2013). Additionally, celebrities
along with community leaders such as tennis player Arthur Ashe, British singer Freddie Mercury, and co-founder of the Pediatric AIDS Foundation, Elizabeth Glaser died from AIDS-related complications. Other celebrities such as professional basketball player, Magic Johnson and Olympic Gold Medal diver, Greg Louganis announced that they were HIV positive (KFF, 2013). The vast media attention HIV/AIDS received during this time was also reflected in different theatre plays and movies such as *Angels in America* (1991) and *Philadelphia* (1993).

The second half of the 1990s was completely different than the first half for a number of reasons. For example, in 1994, the first protease inhibitor (Saquinavir) and the first non-nucleoside reverse transcriptase inhibitor (Nevirapine) were approved by the FDA. New HIV and viral load tests became available to screen at-risk populations and new efforts were implemented to develop a HIV vaccine and the first time since the epidemic began (KFF, 2013).

With the media attention on prevention and the development of HIV screening tests and drug treatments during this decade, the number of new AIDS cases declined as much as 40 percent and HIV/AIDS was no longer the leading cause of death in people 25 to 44 years old in the United States (KFF, 2013). However, with the development of new drugs, people living with HIV/AIDS (PLWHA) faced a new challenge – the struggle of being adherent to an intense life-treatment regimen associated with several side effects (i.e., nausea, vomiting, and lipodystrophy). In addition to treatment secondary effects PLWHA experienced the difficulty of taking medications at different hours during the day while trying to avoid disclosing their HIV positive status. The high number and combinations of medications PLWHA had to take is believed to have increased drug-resistant HIV strains due to non-adherence by patients.

According to information published by The Henry J. Kaiser Family Foundation (2013), from 2000 to 2010, the U.S. government focused primarily on addressing and incorporating
HIV/AIDS preventive strategies. First, there was an increased effort to make HIV/AIDS treatment and preventive strategies information available to all healthcare workers, PLWHA, and the general population. Second, there was a concerted effort to disseminate education on HIV-preventive measures among the MSM populations in the U.S. due to the dramatic increase in new HIV infections among these groups. These educational outreach measures included the availability of testing, the need for, and proper condom use, modes of transmission, and efforts to reduce the stigma surrounding PLWHA. In addition to the preventive efforts, important agreements between the government and pharmaceutical companies to reduce medication costs and manufacture generic medications were discussed. The appearance of an improved rapid HIV test also happened during this decade. Finally, in addition to many educational programs, human rights of PLWHA improved during this decade as well. One example was the removal of the ban that barred entrance of PLWHA to the U.S. (KFF, 2013).

2.1.2 HIV/AIDS in the world

According to the 2011 World Health Organization (WHO) HIV/AIDS global report, it was estimated that approximately 34 million people were living with HIV/AIDS. Of the total number of people living with HIV/AIDS, 30.7 million were adults, while 3.3 million were children 15 years old or younger.

In 2011, approximately 1.7 million people died from AIDS-related conditions. Of the total number of HIV/AIDS-related deaths, 1.5 million were adults and 230,000 were children. In that same year the WHO global report showed 2.5 million new HIV infections, from which 2.2 million were adults and 330,000 were children (WHO, 2012).
The region of the world most affected by the epidemic is Africa, with approximately 23 million people living with HIV/AIDS, followed by South-East Asia with 3.5 million and the Americas with 3 million people (WHO, 2012).

2.1.3 HIV in the U.S.

In 2012, the U.S. federal government spent $27.7 billion dollars on HIV/AIDS programs. The funds were distributed among different HIV/AIDS-related programs such as healthcare, public assistance, housing, prevention, research, and assistance to other countries to fight the epidemic. In 2013, the approved HIV/AIDS budget for that year reflected an increase of approximately 3%, estimating a total spending of $28.4 billion dollars (KFF, 2012). This increase in funding reflects the government’s efforts to address the societal toll of HIV/AIDS.

According to the CDC (2011), rates of new HIV infection as well as the number of PLWHA in the United States are dramatically increasing. The CDC estimates that nearly 1.1 million people are living with HIV/AIDS in the U.S. with about 56,000 new infections occurring each year. The highest rates (per 100,000 population) of PLWHA in the United States occur in the District of Columbia with 112.5, followed by the states: Maryland with 22.1, New York with 20.6, Louisiana with 20, and Florida with 19.7 (CDC, 2010). Certain groups of the U.S. population are classified as at-risk groups for acquiring HIV/AIDS is based on their demographic and behavioral characteristics. The highest risk for acquiring HIV/AIDS is sexual minority groups, specifically men who have sex with men (CDC, 2011).
2.1.4 HIV in Texas

Since 2008, Texas has reported approximately 77,070 cases of AIDS (CDC, 2010). Texas also ranks 13th amongst all states in people living with HIV/AIDS with 11.1 cases per 100,000 population, and ranks 4th in the nation in cumulative reported AIDS cases. In 2009, the CDC allotted Texas nearly $33 million dollars for HIV/AIDS prevention programs which included surveillance, interventions, and capacity building among others (CDC, 2010; 2011). From the total estimate of PLWHA in the state of Texas, 22 percent are Latinos – indicating that Latinos are the second largest group (African American the first) of ethnic minorities who are living with HIV/AIDS in the state (CDC, 2011).

2.1.5 HIV in El Paso

El Paso County borders New Mexico in western Texas along the U.S.-Mexico border. In 2010, El Paso reported population of approximately 800,000 persons of which 80% are of Latino descent (U.S. Census Bureau, 2010). El Paso borders the Mexican city, Ciudad Juarez. The two cities share similar social dynamics such as having family and friends on both sides of the border, as well as the high two-way commuting rate (Byrd & Law, 2009).

In 2011, El Paso ranked fifth in the state of Texas in total cases of HIV and AIDS diagnosis behind larger metropolitan cities such as: Houston, Dallas, Austin, and Forth Worth (Texas Department of State Health Services [TDSHS], 2012). In addition, in 2008, El Paso ranked first among the U.S.-Mexico border cities in the state of Texas in cumulative cases of HIV/AIDS (AETC National Resource Center, 2008).
2.1.6 HIV and the U.S.-Mexico Border

The U.S.-Mexico border region stretches 2,000 miles from the Gulf of Mexico to the Pacific Ocean between both nations, with a width of 62.5 miles on each side of the border. Four states in the U.S. (California, Arizona, New Mexico, and Texas) share borders with six states in Mexico (Baja California Norte, Sonora, Chihuahua, Coahuila, Nuevo Leon, and Tamaulipas) (United States-Mexico Border Health Commission [USBHC], 2012).

U.S.-Mexico border populations share a unique blend of sociocultural traditions as well as important migratory mobility on both sides of the border. In 2011, the United States Department of Transportation estimated 225.5 million documented crossings to the U.S. from Mexico (including pedestrians, individual and commercial vehicles, trucks, etc.).

Mexico has relatively low rates of HIV/AIDS compared to the U.S. In 2011, the prevalence of the reported HIV cases in the adult population (people from 15-49 years old) ranged from 0.24 to 0.3 percent (CENSIDA, 2012). In recent years, the reported cases of HIV/AIDS in the northern part of the country, specifically the states located on the U.S.-Mexico border, have increased dramatically. Some of the factors that are believed to be associated with this increase are migration, and the drug and sex trades (Strathdee & Magis-Rodriguez, 2008).

The state of Chihuahua ranks second in HIV/AIDS cumulative reported cases among the six Mexican border states. It also ranks 10th of the 32 Mexican states (CENSIDA, 2011). In the U.S. side of the border, Texas ranked first in HIV diagnosis with a rate of 23.5 cases per 100,000 population, and nearly tied for first in AIDS diagnosis with California, i.e., 13.9 per 100,000 population compared to 14.0 of California (CDC, 2012).
2.1.6.1 HIV healthcare on the U.S. Mexico border

Healthcare services are socialized in Mexico, this means that there are available sites in the country that offer primary healthcare and some other specialized services without out-of-pocket costs. Healthcare and treatment for HIV/AIDS falls under this category. Throughout Mexico, there are different federally funded clinics specializing in HIV/AIDS care. The National Center for the Prevention and Control of HIV/AIDS in Mexico (CENSIDA) is the organization in charge of managing HIV/AIDS clinics in the country. Ciudad Juarez has one of the newest specialized clinics (CAPASITS) offering all types of healthcare services to clients, including: referrals to mental health, surgical procedures, dental and eye care, economic and/or dietary support, among other services (CENSIDA, 2012).

Many U.S. residents living on the U.S.-Mexico border struggle to gain access to healthcare services for different reasons such as the high cost of medical visits, lack of health insurance, or providers’ lack of cultural competency. These factors cause many to visit Mexico for health-seeking services such as the purchase medications or to receive healthcare services for different medical conditions (Byrd & Law, 2009). This is no exception for PLWHA in this region. Many people living with HIV/AIDS cross the border into Mexico to receive HIV/AIDS related healthcare, to treat opportunistic infections resulting from their diagnosis, to purchase medications at a lower cost, or to receive traditional complementary and alternative medicine (CAM) such as herbal medications, healers, and traditional healing practices (Zuniga, Brennan, Scolari, & Strathdee, 2008).

In the last 10 years, there has been an increased rate of drug-related violence in the Mexican border states, primarily due to the territorial dispute of trafficking points on the U.S.-Mexico border. Approximately 6,500 drug-related murders occurred in the northern states of Mexico in
2009 (Finklea, Lake, Franco, Haddal, & Krouse, 2010). This violence has affected the everyday lives of residents on both sides of the border. Most notably, it has impacted the ways in which people traditionally crossed the border for healthcare seeking in the region. This is also true for PLWHA. Many PLWHA have stopped crossing the border to receive healthcare in Mexico for fear of getting caught in drug-related violence causing a gap in their usual self-care behaviors and access to care.

2.2 HIV/AIDS in Latinos

Latinos in the United States are disproportionally affected by HIV/AIDS and the infection rates continue to increase annually. In 2010, Latinos accounted for 16 percent of the national demographic population but they accounted for 21 percent of the new HIV infections, which increased from 19 percent in 2009 (CDC, 2012).

In the U.S., about 2,853 Latinos died from AIDS-related complications in 2009 and since the epidemic began, there have been around 95,000 Latinos who died from HIV/AIDS (CDC, 2012). In 2010, the death rate of Latinos with HIV/AIDS was two times higher than non-Latino whites (6.9 to 3.5) (CDC, 2010). The distribution of HIV infection rates in Latinos versus non-Latino whites varies by risk behaviors and gender. According to the CDC (2011) the primary means of transmission in the state of Texas and nation-wide is through male-to-male sex, injection drug use (IDU), and heterosexual sex.

The rate of HIV infection among Latino men is 2.9 times greater than non-Latino white men and according to the CDC (2011), Latino MSM accounted for 81 percent of HIV infections in Latinos overall. Latino females on the other hand, only accounted for 20 percent of the total
cases among this population but their infection rate was 4.2 times greater than non-Latino white females – with heterosexual sex as the primary mode of transmission.

Latinos in Texas have been dramatically affected by HIV/AIDS. In 2008, Latinos accounted for 22 percent of all HIV/AIDS diagnosis in the state. Among ethnic minorities, Latinos have the second highest rates of HIV infection, state and nation-wide (CDC, 2010).

### 2.2.1 HIV in Latino MSM

Men who have sex with men are experiencing a global HIV/AIDS disparity. This ranges from: the re-emergence of the epidemic in this population within countries of all economic levels (WHO, 2013), the difficulties in outreach, prevention, and treatment caused by the HIV+ stigma, discrimination, and criminalization of male-to-male sexual behavior (Beyrer et al., 2011).

Adults and adolescents in the U.S. are infected with HIV primarily through male-to-male sexual contact. It is estimated that 79 percent of all HIV/AIDS diagnosis in males and 61 percent of the overall infections are related to male-to-male sexual contact (CDC, 2012). Estimating that MSM account for approximately 2 percent of the nation’s population but account for more than 50 percent of the new HIV/AIDS cases annually, HIV/AIDS is an important health disparity to address in this population group (CDC, 2012).

In 2009, Latino MSM accounted for more than 20 percent of the new HIV/AIDS infections among the MSM population on the U.S., from which 45 percent of the infections occurred in Latino MSM younger than 30 years old (CDC, 2010). In the state of Texas 82 percent of the newly diagnosed HIV cases in 2011 as well as 55 percent of the total number of PLWHA fell under the MSM transmission category (TDSHS, 2012). The area of El Paso attributes 77.6 percent of its new HIV cases to the MSM transmission category.
The CDC (2012) reported different risk behaviors among the MSM population that increase the chance to become infected with HIV. Some of these risk behaviors include the use of alcohol and illegal drugs which may impair decision-making judgment and increase the opportunity to engage in unprotected sex, discrimination (such as stigma and homophobia) on the basis of sexual behaviors affecting the way the MSM population seek and utilize preventive information and healthcare services. Finally, Latino MSM engage in unprotected sex more often than other MSM groups (Bedoya et al, 2012). This unprotected sex involves primarily receptive anal sex, which has the highest risk for HIV-infection.

2.3 Stress and Depression among Latino MSM

According to Fink (2009), stress is the way that our body responds physically and mentally to a stressor (stimulus or event inducing stress in an individual) that is disturbing or exceeding the individual’s ability to cope. Individuals who are exposed to chronic stress or constant stressful events have a higher risk of engaging in unhealthy behaviors that can generate negative effects (smoking, drinking alcohol, using illicit drugs, or overeating) on the individual’s physical and mental health (Jackson, Knight, & Rafferty, 2010). Such may be the case in the MSM population.

Stress plays an important role in the HIV-infected MSM population. A study conducted by Wohl and associates (2010) showed how stress can affect the way MSM manage their healthcare. The study also reports that from all PLWHA, Latino MSM are the most disadvantaged and the most in need of interventions focused on improving their stress-levels, social support, and quality of life.
Meyer (2003) proposed a model explaining the stress and coping mechanisms of minorities and the impact that the exposure those stressors have on health. Meyer (2003) defines minority stress as the “excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position” (p. 675). Meyer emphasizes that sexual minorities are constantly exposed to this type of stress and that understanding the mechanisms that trigger this type of stress are important to develop health interventions among sexual minorities.

The minority stress model is closely linked to stigma, homophobia, coping mechanisms, and structural violence. It has been used among different groups with characteristics that set them apart from the rest of the majority group within a societal system – such as in the case of obese persons, PLWHA, and sexual minority groups (Meyer, 2003). Sexual minorities experience minority stress at different levels. For example, the common stresses of fulfilling societal expectations and bearing with the negative attitudes of society are heightened in certain groups when they must also maintain non-disclosure of sexual orientation (chronic stressful events). This usually leads to the internalization of those negative attitudes affecting the mental and physical health of this group (Meyer, 2003).
Mental health disorders and treatment are important factors when considering the overall PLWHA health. Several studies have reported a high prevalence and incidence of psychiatric disorders including depression in this group, which they classify as a frequent co-morbidity with HIV infection (Basta, Shacham, & Reece, 2008; Feldman, Weinberg, & Wu, 2012). Approximately half of PLWHA report current or lifetime depressive disorders. In particular, clinical depression is diagnosed three times more often in PLWHA than in the general population (Diaz, Ayala, Bein, Henne, & Marin, 2001; Weiser, Wolfe, & Bangsberg, 2004). After co-infections, it is the second most prevalent condition associated with hospitalizations among PLWHA (Uphold & Mkanta, 2005).

Addressing clinical depression among PLWHA is critical due to the impact it may have on self-care behavior, adherence to antiretroviral therapy (ART) and other medication treatments,
immune function, and HIV/AIDS disease progression. For example, clinical depression has been associated with declines in CD4+ counts, poor adherence to ART medication, and engagement in high-risk behaviors (Uphold & Mkanta, 2005; Porche & Willis, 2006; Gonzalez, Hendriksen, Collins, Durán, & Safren, 2009; Gonzalez et al., 2009; Hooshyar et al, 2010; Feldman, Weinberg, Wu, 2011).

Diagnosis and treatment of depression among Latino PLWHA is crucial. Latinos are disproportionately affected by mental health disparities (Han & Liu, 2005; Himelhoch, Josephs, Chander, Korthuis, Gebo, & HIV Research Network, 2009; Lanouette, Folsom, Sciolla, & Jeste, 2009). This group is significantly under-diagnosed and under-treated for depression compared to non-Latino whites (Ritchie, Radke, & Ross, 1992; Simpson, Krishnan, Kunik, & Ruiz, 2007; Stockdale, Lagomasino, Siddique, McGuire, & Miranda, 2008).

2.4 Social Determinants of Health in HIV/AIDS

According to the WHO (2013), the social determinants of health (SDH) are the socioeconomic factors and structures affecting the health disparities of groups within a population. These social determinants are generated based on the distribution of power and resources. Some SDH are housing, access to food markets, education, healthcare, culture, social support, and socioeconomic conditions (USDHHS, 2013).

Studies have emphasized the importance of the SDH in HIV prevention. For example, Dean and Fenton (2010) stated that the primary social spheres affecting HIV prevention and risk reduction in the U.S. are the community and social level sphere (i.e., substance abuse, being foreign-born, multiple sexual partners); the income and social conditions sphere (i.e., transactional sex, violence); the education level sphere (i.e., health literacy, health promotion);
and stigma (i.e., fear of infection, discrimination); this study addresses the importance that SDH have in quality of life and healthcare in Latino PLWHA, but they are not specifically targeting SDH as the main outcome.

Murri and associates conducted one of the few studies investigating the impact of SDH in PLWHA in 2003. They found that education, the patient’s economic condition, the stage of HIV illness, and the patient’s satisfaction with the information provided by the healthcare provider were the primary social determinants of quality of life (QOL) in PLWHA. Another study, which focused on mental health, explored the importance that coping and social support have on the QOL of PLWHA (Friedland et al., 1996). Findings from this study showed that coping and social support are key elements in reducing the impact that stressors exert on PLWHA. The study also reported that having good social support networks (primarily provided by partners and friends or support groups) and coping skills can significantly improve the QOL of PLWHA by reducing the burden of the stressors experienced by HIV/AIDS patients. Finally, the authors found income to be positively associated with QOL among PLWHA. The following sections will address some of the SDH reported in the body of literature that are involved in the overall well-being PLWHA.

### 2.4.1 Structural Violence

Structural violence is defined as the prevention of individuals or groups from reaching their full potential because of systemic obstacles including economical, cultural, health, legal, and religion, among others (Farmer, Nizeye, Stulac, & Keshavjee, 2006). Structural violence stems from institutions and systems. For this reason, it is difficult to determine individual responsibility.
Structural violence has been identified as one of the primary contributors associated with the increase HIV-infections worldwide. High HIV-infection rates are seen in impoverished populations in which education and healthcare access reach only part of the population and the wealthy (Parker, 2002). In the U.S., high rates of infection tend to occur generally in groups that are segregated according to culture, race, ethnicity, and sexual orientation (especially MSM). These groups often experience poor access to preventive measures and limited services addressing sexual transmitting infections (STI) (Lane, Rubinstein, Keefe, & Webster, 2004). Some examples of structural violence and HIV-infection in the U.S. identified by the authors are high rates of incarceration by race and ethnicity, constrained sexual network, homophobia, and heterosexism.

2.4.2 Stigma towards HIV/AIDS and MSM

Stigma is defined as the negative characteristics applied to a minority group by the rest of society causing that group to experience rejection, prejudice, discrimination, and isolation. The negative characteristics are shaped, based on society’s perception of the group, which in many occasions, tend to be inaccurate (Courtenay-Quirk, Wolitski, Parsons, Gomez, & Seropositive Urban Men’s Study Team, 2006). In the context of illness as in the case with HIV/AIDS, PLWHA are blamed for disrupting the social environment and are treated as the problem, deviating attention from the condition itself, which remains untreated and uncontrolled (Courtenay-Quirk et al., 2006).

PLWHA often have to face discrimination based on their HIV-infection status and depending on which group they fall into, the severity of stigma can increase. For example, children living with HIV/AIDS will experience fewer types of stigma than heterosexual women and men living with HIV/AIDS. HIV/AIDS-affected heterosexual men and women appear to
experience fewer stigmas, compared to MSM and transgender individuals. This conceptualization in which a group has two perceived negative characteristics by society (such as MSM living with HIV/AIDS) has been termed ‘double stigma’ (Kowaleski, 1988).

The HIV-infected MSM have experienced a ‘double stigma’ since the beginning of the AIDS epidemic when it was termed GRID (Gay-Related Immunodeficiency Disease). More than three decades later, stigma remains a major problem for this group. Society keeps discriminating and segregating this group at different levels (Herek & Capitanio, 1993). Novick (1997) believes that stigma is one of the primary factors associated with increasing rates of HIV-infection in minorities due to the difficulties minority groups (such as MSM) have with respect to accessing healthcare, finding providers that are culturally competent in addressing their healthcare needs, and coping with the strong discrimination healthcare workers, employers, and co-workers have towards these groups.

Stigma has negative consequences in the mental health of HIV-infected MSM. For example, Courtenay-Quirk and associates (2006) state that stigma increases the levels of depression, anxiety, and suicidal ideation in HIV-infected MSM as well as make it more difficult to properly cope with stressors. Stigma can be internalized by PLWHA. This internalization of prejudice, discrimination, cultural norms, and feelings of shame, guilt, and self-hatred can affect the mental health and healthcare behaviors of this group (Sayles, Wong, Kinsler, Martins, & Cunningham, 2009). Some of the healthcare behaviors that may be affected by internalized stigma in PLWHA are adherence to ARV medications, doctor visits, and restocking medication. Many PLWHA do not seek access to healthcare for fear of having their HIV+ status disclosed (Sayles et al., 2009).
Latino MSM in the U.S. not only experience high levels of stigma as previously mentioned, but they also can experience stigma based on their ethnicity, nationality, and cultural beliefs which are exclusive to their Latino heritage. For example, Latino MSM of Mexican origin struggle with disclosure of sexual orientation due to ‘machismo’ (see section 2.3.4) (Solario, Currier, & Cunningham, 2004). This can increase the risk of engaging in high-risk behaviors such as unprotected sex and substance abuse, which may lead to HIV-infection or transmit it to others (Solario et al., 2004). Also, the impact of stigmatization by family members on Latino PLWHA plays an important role in social support and mental health outcomes (Varas-Diaz, Serrano-Garcia, & Toro-Alfonso, 2005).

2.4.3 Culture

Latino culture perceives male-to-male sexual behaviors as a sign of weakness and represents shame and dishonor to the family. Men who engage in male-to-male sexual behaviors are not considered “real” men (Brooks, Etzel, Hinojos, Henry, & Perez, 2005). This cultural belief causes some Latino MSM maintain their sexual preference hidden and secretly engage in sex with men while maintaining a heterosexual lifestyle (Brooks et al., 2005).

The lack of effectiveness in connecting Latino MSM to healthcare services has failed primarily because the interventions do not specifically targeting the cultural needs of this group. For example, Latino MSM may not self-identify as gay or homosexual due to cultural conceptualizations (e.g. if Latino MSM performed the active [penetrative] role in a sexual encounter). This can result in Latino MSM ignoring the information or services because they do not feel identified with the targeted population. This places them at higher risk of becoming infected with HIV (Herd, 2001).
Culture also has been noted to affect the way PLWHA sought and received healthcare, especially Latino PLWHA. Some of the most common culture-based barriers Latinos experience when seeking healthcare are language and treatments not fulfilling their cultural needs and practices (Rios-Ellis, et al., 2008).

2.4.4 Machismo

Machismo is an important sociocultural factor that has been limited to the transmission of HIV among Latino MSM. Machismo is associated with strength, power, and constant efforts to prove masculinity to others (Jaramba, Kennamer, Poppen, Hendricks, & Bradford, 2005). The most common behavioral traits of machismo in MSM are poor self-control in refraining from sexual encounters, a need to be the dominant sexual partner and seeking penetrative sex as the primary sexual act, early sexual debut, and a lack of condom use due to the belief that this threatened masculinity and performance (Jaramba et al., 2005).

Machismo influences condom negotiation in MSM. The high cultural expectancies of sexual performance and the belief that condoms will interfere in meeting those expectations create an environment of high risk for HIV infection, primarily for the receptive partner. Many Latino MSM will not request or require condom use from their sexual partner for fear of getting into an argument or fight, or for fear damaging the relationship (Rios-Ellis, et al., 2008).

2.4.5 Homophobia

Homophobia has been defined as the irrational fear of groups who express love and sexual desire for people of the same sex (such as the LGB groups). This irrational fear can lead to physical, verbal, and emotional aggressions towards these groups (Pharr, 1997). Homophobia
in combination with other factors such as socioeconomic problems and lack of access to support
groups has been shown to significantly increase mental health issues (e.g. anxiety, stress, and

Homophobia can be internalized by MSM and other sexual minorities. This happens
when MSM experience shame and guilt for having sexual desires for other men (Jaramba et al.,
2005). Some consequences of internalized homophobia are the inability to self-identify as MSM,
substance abuse, and high levels of stress, anxiety, and depression. Like machismo, internalized
homophobia has been connected with a high risk of acquiring HIV and as a barrier to participate
in LGBT activism and health promotion groups (Jaramba et al., 2005). Although there are often
positive benefits to mental health which come along with affirmative MSM self-identification,
unfortunately, Latino MSM experience homophobia and hostile cultural environments which
very often increase their levels of anxiety, stress and depression in comparison to Latino
heterosexual men (Juster, Smith, Ouellet, Sindi, & Lupien, 2013). This outcome leads MSM
groups to not disclose or self-identify as MSM (Jaramba et al., 2005; Ayala et al., 2012).

2.5 Theoretical Framework

The proposed study is based on three theories associated with health and health behavior:
the Transactional Model of Stress and Coping, the Social Ecology Model of Health Promotion,
and the Health Belief Model (HBM).

2.5.1 Transactional Model of Stress and Coping

This study utilizes as a theoretical base the transactional model of stress and coping
developed by Lazarus and Folkman. This model states that a person’s response to an adverse
event will be dictated by the person’s view of how threatening that adverse event is to his/her well-being and the perceived resources available to decrease or eliminate the threat (Lazarus, 1966; Lazarus & Folkman, 1984).

The Lazarus and Folkman stress and coping model has different constructs. The following section provides an overview of the main constructs and the role that each of them plays in the model.

**2.5.1.1 Constructs in the Transactional Model of Stress and Coping**

*Stress/Stressor:* similarly to the previous definition of stress in this paper, Lazarus and Folkman (1984) defined stress as the body’s response to an interaction with the environment (stressor) that exceeds the person’s ability to properly manage the situation.

*Appraisal:* the transactional model of stress and coping identifies three different types of appraisal: primary appraisal, secondary appraisal, and reappraisal. *Primary appraisal* is defined as the evaluation of the stressor or situation. This evaluation allows the individual to assess the potential harm of the situation. *Secondary appraisal* is defined as the process to assess the coping options available that the individual could utilize to manage the stressor. This type of appraisal may appear simultaneously with primary appraisal and in other occasions occurs after primary appraisal. *Reappraisal* is defined as the process of evaluating previous primary or secondary appraisal over time, which can result in ranking the stressor with a lower or higher threat level than at the exposure level. The model also provides the construct of *challenge*, which it is defined the possible gain or benefit of being exposed to the stressor. This construct is commonly associated with primary appraisal (Lazarus, 1966; Lazarus & Folkman, 1984).

Another important construct in the Lazarus and Folkman model (1984) is *coping*, which is defined as the cognitive behavioral efforts minimize and manage the effects that a stressor
generates in the individual. The coping construct is divided into two main types: problem-focused coping and emotion-focused coping. *Problem-focused coping* consist in analyzing the stressful event and come up with solutions that change the event (or the part of the event that can be modified). This type of coping sometimes requires the learning and adoption of new skills. *Emotion-focused coping* on the other hand, consist in adopting behaviors that contribute to decreasing emotional distress. Emotion-focused coping does not change the event directly. This type of coping is commonly used on situation where the event cannot be change (i.e. death of a loved one).

![Transactional Model of Stress and Coping](image)

Figure 2. Transactional Model of Stress and Coping

2.5.2 Social Ecology Model for Health Promotion

In health and behavioral sciences there are different models and approaches used to explain the influence that the environment has in a person’s physical and behavioral health (Sallis, Owen, & Fisher, 2008). The model selected for this project is the Social Ecology Model for Health Promotion developed by Stokols (1992, 1996, & 2003).

The model has four primary core themes that link the interactions between the behavioral practices and the environment surrounding the individuals. First, the well-being of a person is influenced by the environment and the person’s individual characteristics. Therefore, special considerations about the interaction between the environment and the individual must be conducted when assessing for the individual’s well-being. Second, the environment is a multilevel sphere and it can lead to physical or social (i.e. social, cultural, and political among others) interactions. Third, the individual can interact with, and be affected by the different environmental levels independently. Fourth, there is a mutual effect created by the interaction between the individual and the environment; an individual can affect or chance an environmental condition, but that changed environmental condition will affect the individual and vice-versa (Stokols, 1992; 1996).
2.5.3 Health Belief Model

The HBM has been widely used for HIV prevention strategies, but also has been used in the context of HIV/AIDS healthcare. The following section will explain the model and its constructs, followed by a detailed description of how each construct is represented in this study with a sample of PLWHA.

The Health Belief Model (HBM) is a health behavior change theory that it is based on the rational decisions made by individuals by balancing barriers and benefits of actions affecting
their health (Munro, Lewin, Swart, & Volmink, 2007). The HBM was developed by Rosenstock in 1966 to explain the lack of participation of people in disease prevention programs (DiClemente & Peterson, 1994). In later years, the model was updated, new constructs were added, and also it was adapted to include a person’s response to symptoms (Rosenstock, Strecher, & Becker, 1988; DiClemente & Peterson, 1994).

The HBM states that a person will be motivated to act in a healthy way if he or she feels susceptible to a severe health issue. The model has four main core constructs that explain the appearance of a behavior: Perceived Susceptibility, Perceived Severity, Perceived Benefits, and Perceived Barriers (Carpenter, 2010). The following figure represents the constructs’ dynamic of the HBM.

![Figure 4. The Health Belief Model](image-url)
DiClemente and Peterson (1994) describe the basic constructs of the HBM as follows:

*Perceived Susceptibility* construct is defined as a subjective perception of the risk of developing a health condition. If the health condition is already present, then it is defined as the perception of acquiring the health condition again, and the acceptance of that diagnosis. For the purpose of this study, perceived susceptibility is how participants view the level of risk to have HIV/AIDS-related complications (physical and mental) due to different social determinants that may interfere with their well-being.

The *Perceived Severity* construct is defined as the seriousness of having a health condition. The person evaluates all possible consequences, including the medical ones (such as pain, fatigue, death) and the social ones (e.g. how work, family, friends, etc. will get affected if contracts the health condition). In this study, the perceived severity is viewed as the level of HIV-related complications (physical and mental) participants believe they will experience by being exposed to specific social determinants that are affecting their well-being.

*Perceived Benefits* construct is the belief of how the actions available to the person will effectively reduce the threat of contracting a health condition. The person may know that he or she is susceptible or has a health condition perceived as serious and this will create a force of action, but the action might not be taken unless it is perceived as beneficial to prevent or treat the health condition. In this study the construct of perceived benefits is linked to the health beliefs and practices participants engage in to improve their well-being. Participants will be more willing to engage in a health practice if they believe that by doing so, their health will be considerably improved.

*Perceived Barriers* construct is defined as the negative aspect of the health action. The person needs to evaluate if the health action’s outcome is worth more than what it will take to
implement the action. Some examples of perceived barriers that participants may encounter in achieving and maintaining a good level of health are if participants experienced any treatment side-effects, how time consuming will it be to perform a health practice, distance between the person’s home and the community health clinic, if the health practice is going to be expensive or painful, etc.

The constructs described above are the basic constructs of the HBM. As the model was expanded and refined, new components were incorporated or created (self-efficacy, cues to action and modifying variables), and some are combinations of two constructs, like the case of perceived threat.

*Perceived threat* is the combination of the perceived susceptibility and the perceived severity constructs (Rosenstock et al., 1988). When the perceived threat represents a real risk for the person, the new health behavior (action) is often adopted (Hayden, 2009).

*Self-efficacy* theory was first introduced by Bandura (1977) as an integration of beliefs concerning the capability of doing, coping, and sustaining behaviors that will help to overcome obstacles and aversive situations.

Although the concept of self-efficacy was not adopted by the HBM until 1988, it was implied under the perceived barriers construct. The most important contributions of including self-efficacy as a component in the HBM were that it delimited the barriers dimension and suggested new lines for research and practice (Rosenstock et al., 1988).

*Cues to Action* are defined as people, events, situations, or things that can influence a person to change his or her behavior (Hayden, 2009); some examples can be reminders, mass media campaigns, billboards, advice from others, an accident, etc. Although this component has been rarely studied, it has been found as an important trigger of new behavior (Carpenter, 2010).
*Modifying variables* are individual characteristics that indirectly affect the behavior by influencing personal perceptions (susceptibility, severity, benefits, and barriers) some examples are demographics, past experience, skills and motivations (Carpenter, 2010).

Although the HBM has been widely used for predicting behaviors, it also has been criticized for failure to include social and cultural variables that directly influence behavior (Macintyre et al. 2001; Rankin et al. 2009). The proposed study is based primarily on the health belief model, but it also incorporates different constructs and variables such as the minority stress model, social determinants of health, and participants’ demographics (fig. 3).
CHAPTER 3
METHODOLOGY AND RESEARCH APPROACH

3.1 Introduction, Rationale, and Overview of Methodological Design

The purpose of this phenomenological study is to explore the self-reported level of depression, to describe the sources of stress coming from SDH, and to investigate the health beliefs and practices of Latino MSM living with HIV/AIDS in a U.S.-Mexico border city. The investigator contends that a better understanding of these phenomena will assist healthcare providers to improve existing programs and implement new ones that address the healthcare issues and needs of this population. The present qualitative research study addresses four major research questions: 1) What is the level of depression in a sample of HIV/AIDS infected Latino MSM on the U.S.-Mexico Border? 2) Which SDH affect their stress? 3) What are their health beliefs and practices? 4) What are the strategies or behavioral mechanisms they use to reduce their stress levels?

This chapter provides an overview of various aspects of this study. First, it presents an overview of the two main methodological research designs (qualitative and quantitative), and then offers rationale for using a qualitative approach to this research problem. The chapter then continues to explain the process of conducting phenomenological research as well as its benefits and challenges. This is followed by a description of how the study sample was determined and the information needed to answer the research questions. Using this information, the chapter will present an overview of the research design and the data collection methods that were used in the study. The final sections of the chapter feature a description of how the data analysis and
interpretation were implemented, the ethical considerations for the study, and the establishment of trustworthiness.

3.1.1 Overview of Quantitative and Qualitative Research Design

Health research is guided by two principal paradigms: quantitative and qualitative methodologies (Yoshikawa, Weisner, Kalil, & Way, 2008). Quantitative research involves numerical data to make representations of the world. Information is collected with instruments such as surveys and questionnaires that transform participants’ responses into numerical codes that can be generalized to a larger population (Yoshikawa et al., 2008). By contrast, qualitative research produces findings using means other than quantifiable or statistical methods (Hoepfl, 1997). Qualitative research takes place in the natural setting where the phenomenon occurs in order to obtain the same understanding of a phenomenon as how the people experiencing it would perceive it themselves (Denzin & Lincoln, 2005). With this type of research, investigators have little control over the experience being studied and require multiple methods of exploration to understand the phenomenon.

Qualitative and quantitative research methodologies have opposite ways of approaching the study of a phenomenon; and over the years, there have been numerous debates about the scientific contributions that quantitative and qualitative research paradigms offer to the growth of scientific knowledge (Hoepfl, 1997). In recent years, many researchers have combined strategies from both methodologies, to a certain extent, in order to enrich and expand the scope of their studies (Brooks et al., 2012). The following table describes the main characteristics of the quantitative and qualitative research approaches:
Table 1: Comparison of Quantitative and Qualitative Research (adapted from Pope & Mays, 1995)

<table>
<thead>
<tr>
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<th>Quantitative</th>
<th>Qualitative</th>
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<tbody>
<tr>
<td>Theory:</td>
<td>Based on structure</td>
<td>Based on action</td>
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<tr>
<td>Methods used:</td>
<td>Survey, experiment, scales,</td>
<td>Interview, focus groups,</td>
</tr>
<tr>
<td></td>
<td>questionnaires, etc.</td>
<td>observations, etc.</td>
</tr>
<tr>
<td>Research Question:</td>
<td>How many outcomes or variables...?</td>
<td>What is the phenomenon...?</td>
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<td></td>
<td>(Quantity)</td>
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<tr>
<td>Type of reasoning:</td>
<td>Deductive</td>
<td>Inductive</td>
</tr>
<tr>
<td>Sampling method:</td>
<td>Statistical</td>
<td>Theoretical</td>
</tr>
<tr>
<td>Strength:</td>
<td>Reliability</td>
<td>Validity</td>
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### 3.1.2 Rationale for Qualitative Research Design

The main objective of conducting qualitative research is to provide an in-depth description of the phenomenon using conceptual and theoretical approaches (Welford, Murphy, & Casey, 2011). Creswell (2007) provides the following characteristics of the components of qualitative research:

*Natural setting*: The data is collected from the place where the participants experience the phenomenon, which is being studied. Researchers do not collect the data in a lab or a controlled setting, and they generally do not provide the data collection instruments to participants.

*Researcher as key instrument*: The research does not rely on instruments or measures developed by other researchers – the researcher is the person in charge of gathering the information.

*Multiple sources of data*: Qualitative researchers often utilize a variety of methods to collect data such as interviews, documents, and focus groups.
**Inductive data analysis**: The researcher creates the categories and themes from the information collected. In order to do this accurately, the researcher must continually review the collected information to verify that the created themes represent the participants’ meanings. For increased validity, this may be done in collaboration with participants.

**Participants’ meaning**: Qualitative researchers focus on the meaning of the phenomenon to the participants themselves, not an abstract meaning assigned by the researcher or previous literature.

**Emergent design**: Researchers do not follow a pre-established protocol or design. This may change at any phase of the study if it gives a better understanding of a participant’s perspective of the phenomenon.

**Theoretical lens**: Researchers often follow a theoretical tradition to organize the study.

**Interpretive inquiry**: Researchers, participants, and readers can provide multiple points of view to the problem being studied.

**Holistic account**: Researchers develop a framework to examine the problem by taking into account multiple perspectives and factors.

There are many reasons why researchers conduct qualitative research. Qualitative research may be desirable for the examination of a phenomenon for any of the following reasons: the phenomenon of interest has not been well studied, the researcher wants to examine the phenomenon from a variety of perspectives and wants to give equal weight and significance to each participant’s contribution, there is a need for the development of theories to explain a phenomenon because the existing ones do not fully explain it, there is an initial need to identify variables of a construct so that they may be measured subsequently, or there are not enough reliable or valid quantitative measures to understand the phenomenon. Qualitative research then,
offers the understanding of the phenomenon so quantitative measures can be adapted to measure the construct of interest (Hoepfl, 1997; Creswell, 2007).

This research uses a qualitative methodology because little research has been done previously to understand the meaning of the lived experiences, the health beliefs and practices, and the SDH that affect the physical and mental health of Latino men living with HIV/AIDS on the U.S.-Mexico border. Using a qualitative research approach to these issues provides an in-depth understanding of the phenomenon and helps to identify health-related practices for combating stress that could have important implications for future research studies in this area.

3.1.3 Overview of and Rationale for the Phenomenological Tradition

This qualitative study intends to obtain an in-depth understanding of the factors affecting the well-being of men living with HIV/AIDS in a U.S.-Mexico Border city using phenomenology as the research approach. Phenomenology is both a philosophy and a methodology for conducting research. Edmund Husserl is considered the founder of phenomenology. He defined it as a science that describes the world through a process of pure consciousness (Earle, 2010). Husserl also suggested that people explore the world through their senses, achieving knowledge only from the analysis and interpretation of perceived things (Welford, Murphy, & Casey, 2011). Phenomenology as a methodology seeks to understand the world by examining the meanings and interpretations provided by the participants’ lived experiences. It focuses on the commonalities reported by the participants as they experience the phenomenon in order to gain a fuller explanation of the inquiry’s nature (Creswell, 2007; Welford, Murphy, & Casey, 2011).
The two most important phenomenological approaches used in scientific research are transcendental and hermeneutic. Transcendental phenomenology proposes that the knowledge of a phenomenon comes with its rigorous and conscious exploration utilizing primarily three main constructs; *intentionality* (being conscious and aware of a phenomenon), *eidetic reduction* (bracketing our personal experience about a phenomenon to know the essence of a phenomenon), and *constitution of meaning* (identifying essences representing the perception of persons experiencing the phenomenon) (Earle, 2010). The term hermeneutic phenomenology was derived from the Greek mythological figure Hermes. He was both the messenger of the gods and also the deity who interpreted hidden messages for mortals; therefore, the meaning of the word as we know it is *interpretation* (Vandermause & Fleming, 2011). It was the German philosopher Martin Heidegger, a student of Husserl, who developed the aforementioned philosophy that is focused on the meaning of existence following an ontological approach (as opposed to the epistemological view of Husserl). The constructs used in hermeneutic phenomenology are *daisen* (existence) and *temporality* (existence over time) (Vandermause & Fleming, 2011). Heidegger opposed the *eidetic reduction* because he could not conceive the understanding of a phenomenon without a pre-conception of it. His ‘hermeneutic circle’ was based on the reciprocal interaction of pre-understanding – the knowledge we have of the phenomenon as a whole just for existing in the world, and understanding – examining all parts of the phenomenon (Earle, 2010).

This phenomenological study will follow a hermeneutic approach due to the assumption that it is impossible to separate the pre-established conceptions that both the researchers and the participants have of the phenomenon from their experiential history of that same phenomenon. The approach assumes that all the pre-existing knowledge and experiences (such as culture,
family value, and society) are important in shaping how participants and the researcher understand and interpret the phenomenon (Laverty, 2003).

3.1.4 Procedures in Conducting Phenomenological Research

The process of conducting phenomenological research has been widely addressed in the literature by several writers, and this type of analysis is very highly structured. Creswell (2007) provides the following guidelines for conducting phenomenological research:

The first step is to identify the phenomenon of interest and evaluate the importance of studying it. Next, the researcher must decide if phenomenology is the best approach to explore the phenomenon. This is not a given, but rather an important part of the process. Once phenomenology is decided to be the best approach, the researcher should address the philosophical assumptions and bracket off their own experiences with the phenomenon if transcendental phenomenology is used.

The second step is conducting a data collection process, which follows the previously described phases. It is important that the data collected for the study is from participants directly experiencing the phenomenon in question. Data can be collected using different qualitative collection methods such as in-depth interviews, focus groups, observations, journals, field notes, and poetry.

During the second step, Creswell (2007) emphasizes that during the interview process it is important to focus on two broad questions. One question is about the participants’ experience with the phenomenon, and the other one is to explore which situations are affecting their interaction with the phenomenon. In order to analyze the data collected from the completed interviews, detailed and verbatim transcriptions must be conducted and then organized based on
the principal research questions to facilitate coding (horizontalization) and the developing of themes (clusters of meanings) from relevant statements. The themes are then used to describe how the participants experienced the phenomenon (textual description), and they are also used to describe the context that influenced the way the participants experienced the phenomenon (structural description). The researchers can also write about their own experiences with the phenomenon.

Finally, from those textual and structural descriptions, the researchers write about the “essence” of the phenomenon being studied based on the similarities found in the experiences that participants reported while living the phenomenon.

3.1.5 Challenges in Conducting Phenomenological Research

Some of the challenges presented in using a phenomenological approach are that the recruited participants are required to have experienced the phenomenon of interest. The main goal of the phenomenology is to create a common understanding of the research question. In order to achieve this understanding, the researcher-recruited participants who are directly experiencing the phenomenon. The sample section in this paper explains the process in more detail.

Another challenge is that the investigator can experience difficulties in bracketing-off their personal experiences and background from the research (if the researcher follows a transcendental phenomenology model) along with managing how much of their personal history with the phenomenon being explored will be introduced into the study (Creswell, 2007). This investigator addressed this challenge by describing his level of knowledge and familiarity with the phenomenon. Also, the researcher utilized member-checking as one of his strategies to
increase the validity of the study. This method is described in more detail in the trustworthiness section of this study (section 3.8).

3.2 Participants/Research Sample

This section provides information about the characteristics of the study sample, the inclusion and exclusion criteria, and the research site.

3.2.1 Sample

The sample that was used in this study comes from a large pool of individuals utilizing a variety of services at a HIV/AIDS community-based clinic located on the U.S.-Mexico border. The services offered include direct treatment of HIV and/or other health conditions related to their HIV/AIDS infection. Most of the people utilizing services at this clinic lack health insurance and qualify for public assistance based on income. The study recruited 40 participants using a hybrid sampling strategy between convenience and purposive sampling. Barbour (2001) states that sampling in qualitative research aims to reduce bias by checking a sample’s specific differences and similarities with their respective group variations. By using a purposive sampling the researcher was allowed to include the participants considered “outliers” (e.g. participants recently diagnosed with HIV-infection and participants living with HIV/AIDS for more than 20 years) that are usually not included in qualitative research.

The sample size allows the researcher to interview enough participants and include participants considered “outliers,” which will help reduce bias in the study, achieve data saturation, and increase trustworthiness (Barbour, 2001). The targeted sample group is LMSMLHA.
3.2.2 Participant Inclusion Criteria

In order to enroll in this study, participants must meet inclusion criteria. Inclusion criteria include: self-identification as Latino; self-identification as gay, bisexual, MSM, or having a male partner on their last relationship; diagnosed with HIV or AIDS; age 18 years or older; referred by the community-based clinic staff; and currently receiving some type of healthcare treatment from the community-based HIV/AIDS clinic where the study was conducted.

3.2.3 Exclusion Criteria

Individuals excluded from participating in the study are those who did not meet the inclusion criteria. In addition, participants were excluded if they had any type of evident cognitive impairment that prevented them from signing or understanding the informed consent. For example, participants under the influence of alcohol or illicit drugs, or who have a medical/psychiatric diagnosis that affects their decision-making ability were excluded from the study. Men who were not referred by the clinic staff, who were not receiving any type of healthcare service at the community-based clinic, or who do not identify themselves as men who have sex with men were also excluded from the study.

3.2.4 Research Site

The research site is a HIV/AIDS community-based center located on the U.S.-Mexico border of El Paso/Ciudad Juarez. The clinic was established by a non-profit 501(c)3 organization and offers specialized healthcare services for sexually transmitted infections (STI’s) including HIV/AIDS, as well as: pharmaceutical, social, transportation, and housing services to all their clients based on their needs and socioeconomic status. Anyone residing in the El Paso region is
eligible for services, whether or not they have health insurance. If a client requires a service not available under the healthcare center’s purview, the client is referred to another healthcare agency such as mental health and dental care, which often times offers at no extra out-of-pocket cost. The clinic is part of a set of community-based clinics that emerged in 1967 as a result of the healthcare needs of the people living in El Paso’s, “Segundo Barrio” (second ward) - the third poorest zip code in the country. The clinic primarily targets the Latino population that has traditionally experienced economic, linguistic, and cultural discrimination.

3.3. Information Needed

This phenomenological study is focused on a sample of HIV-infected MSM obtaining services at a community-based clinic located in the city of El Paso on the U.S.-Mexico border. The information collected in this study was guided by three research questions. The framework for the data collection process has been distributed in the following categories to structure and determine the methods used to collect the information required to answer the research questions:

<table>
<thead>
<tr>
<th>Research question</th>
<th>Information needed</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Throughout their experience of living with HIV/AIDS, what are the factors affecting the participants’ depression, stress and physical health.</td>
<td>Experience living with HIV/AIDS, co-morbid conditions, economic status, border violence, support networks, etc.</td>
<td>Individual in-depth interview</td>
</tr>
<tr>
<td>How do participants attempt to cope with stressful daily-life events?</td>
<td>Practices used by participants specifically to decrease levels of stress.</td>
<td>Individual in-depth interview</td>
</tr>
<tr>
<td>What beliefs and practices do participants believe help to keep them healthy?</td>
<td>Diet, exercise habits, complementary and alternative medicine practices, faith-based practices, etc.</td>
<td>Individual in-depth interview</td>
</tr>
</tbody>
</table>
3.3.1 Demographic Information

For this section, the investigator collected information using demographic variables. Some specific demographics that were collected from the participants are: sex, age, education level, time living in the area, people with whom the participant live, language proficiency, health insurance status, treatment regimen, co-morbid infections, relationship status, and depression level.

3.3.2 Perceptual Information

Information collected in this section is based on participants’ perceptions, beliefs and practices. The primary information for this section was collected using a semi-structured, individual, in-depth interview and it explored the beliefs and practices participants use to keep themselves healthy, what daily-life events they consider to negatively affect their sense of well-being, and which behaviors or mechanisms they use to cope with those negative daily life events.

3.3.3 Theoretical Information

The theoretical information for this study was based on available scientific literature and theories in qualitative research. The study research questions, the study aims, and the process of creating and applying the data collection instruments are supported by different components of the transactional model of stress and coping, the social ecology model for health promotion, and the health belief model. In this study, the questions from the interview guide were created based on constructs from these theoretical models.
3.4. Research Design overview

The research followed a qualitative research methodology. The following diagram explains the research design for this study. This framework was created and adapted based on Maxwell’s interactive research design approach (Maxwell, 2008):

The above research framework shows how the research design is actively related and connected to each of its parts with the research questions being at the core. The upper section of

Figure 5. Interactive research design (adapted from Maxwell’s Interactive model of research, 2008)
the framework represents the close relationship between the study goals, the research questions, and the conceptual framework. In other words, the study goals need to be developed based on the research questions and on the theories and literature available. The upper part of the research framework also states that the goals and research questions determine the theories used and the impact those theories will have on the study.

The lower section of the framework represents the interaction between the methods, the research questions, and the implementation of trustworthiness in the study. The selected methods need to be the appropriate ones in order to collect the information needed to answer the research questions. The research questions influence both the data collection instruments and the trustworthiness methods of the study. The data collection instruments and the type of trustworthiness methods are also interacting with each other because the strengths and weakness of the data collection instruments will define the type of methods needed to assure trustworthiness in the study.

Finally, two indirect interactions (dashed lines) are made between the study goals and the methods, the conceptual framework, and trustworthiness. The goals will influence the methods needed to collect the information, and the methods will provide the information needed to shape and meet the study goals. On the other hand, the theories used to develop the study will influence the prioritization of the trustworthiness methods, and those methods will also appropriately inform the theories used in the study.
3.4.1. Steps to carry out data collection for the study

Each data collection method that was implemented in the study followed particular steps and procedures to correctly collect the information. The following diagram represents the process for data collection methods in this study:

![Diagram of the study's data collection process](image)

Figure 6. Diagram of the study’s data collection process
3.4.2 Recruitment Process

The recruitment process was conducted at a HIV/AIDS community-based clinic in the city of El Paso, Texas. Interviews were carried out at a private office in the clinic in both English and Spanish, depending on the participant’s language of preference. The private office was used specifically for study purposes. The clinic staff recruited participants and referred individuals who met the inclusion criteria to the researcher. Once the individual was referred, the researcher met with the participants and evaluated their eligibility for the study.

The clinic staff recruited participants primarily while they waited in the clinic for an appointment for laboratory tests, doctor’s appointments, or services provided by caseworkers. Clinic staff asked participants if they would like to participate in an interview about their personal experience of living with HIV/AIDS. If a participant agreed to enroll in the study, the clinic staff referred the participant to the researcher to set an appointment for the interview. Before starting the interview, the participant was asked for their preferred language (English or Spanish). After that, the researcher gave the informed consent to the participant and explained that participating in the research is completely voluntary, confidential, and that they could withdraw at any phase without affecting the treatment and care he is receiving at the community-based clinic. After a participant read the informed consent form and before he signed it, the researcher clarified any questions or doubts the participant may have about the study. When the participant agreed and signed the informed consent, the researcher started with the demographics form, followed by the in-depth interview. All interviews were audio-recorded. Participants were given $30.00 U.S. dollars at the end of the in-depth interview as compensation for the time spent
participating in the study. Before setting-up the incentive amount, it was discussed with the community-based clinic director and considered non-coercive.

3.5 Data Collection Methods

This section describes the different types of quantitative and qualitative data collection methods that the researcher utilized to obtain information from the participants in the study.

3.5.1 Socio-Demographics Characteristics

A socio-demographics questionnaire was used to collect demographic information (age, sex, location, sources of income, etc.) as well as health related indicators (such as insurance, health-related conditions, places receiving healthcare, etc.) from the sample being interviewed or studied.

The socio-demographics questionnaire is considered an important part of the main qualitative interview because it collects background information of the participants that can influence how the phenomenon is experienced (Britten, 1995). In this study, instead of giving the form to the participants to fill out on their own, the socio-demographics questionnaire was integrated at the beginning of the in-depth, semi-structured interview. This facilitated the transition into the interview portion and promoted rapport between the interviewer and interviewee.

3.5.2 Beck Depression Inventory II (BDI-II)

The BDI-II is one of the most widely used clinical instruments for measuring self-reported depressive symptomatology. The BDI-II consists of 21 items that explore two main areas of depression, the somatic-affective (12 items) and the cognitive components (eight items),
and one item focused on self-criticalness. Results are based on the DMS-IV criteria for major depressive disorders (Penley, Wiebe, & Nwosu, 2003).

The English and Spanish versions of the BDI-II have been used with different population groups, including Latino groups living on the U.S.-Mexico border region of El Paso-Juarez. Wiebe and Penley (2005) tested both versions of the BDI-II on a predominantly Latino college student population sample ($n = 937$). Results showed that both versions were highly correlated (cross-language ICC= 0.76, $p < 0.001$) presenting good factorial validity ($Z > 4.6$, $p < 0.05$), and reliability scores $\alpha = 0.89$ for the English version and $\alpha = 0.91$ for the Spanish version.

Another study conducted by Penley, Wiebe, & Nwosu (2003) tested the reliability and validity of the English and Spanish BDI-II on a chronically ill sample from the El Paso-Juarez region. The research team used both versions of the measurement tool in a population undergoing hemodialysis. The results also showed correlation between the two versions and non-significant difference between them.

The primary strengths of the BDI-II are its validity and reliability across different groups, cultures, and languages (English and Spanish versions). It also has been shown to be a good assessment tool for clinical populations (Penley et al., 2003). The BDI-II it is a tool that is quick and easy to apply and evaluate.

3.5.2.1 Application process of the BDI-II

The application process of the BDI-II is very simple. Beck and associates (1996) formulated the steps for self-administration and oral administration. For self-administration, Beck states that the scale will be given to the participant and they will be asked to read the instructions and answer each item as indicated. The interviewer will need to emphasize to the
participant to answer the questions according to how they have been feeling for the last two weeks. If they have any questions, they can openly ask the interviewer for help.

For participants who have difficulty reading, are unable to read, or prefer to have the scale read, Beck and associates (1996) provide a well-explained set of steps to administer the depression scale orally providing to the interviewer a suggested text to be read to the participant explaining the instructions. Following the reading of the instructions, the researcher will hand a copy of the scale to the participant. Then, the interviewer reads all statements in the first group followed by asking the participant to indicate the statement of his choice. Finally the interviewer will continue reading the statements of each group out loud.

It is important at the end of the administration of the scale (regardless of the modality) to inspect that each item has been answered. If an item is not answered or has more than one option marked, the interviewer must revisit that item and ask the participant for the correct answer.

3.5.3 In-depth Semi-structured Interview

In-depth, semi-structured interviews are one of the most used instruments for the collection of qualitative data. The purpose of interviews is to understand the meanings that people attribute to a phenomenon due to their interaction and exposure. This develops a common understanding that will contribute to future studies in the creation of a theory or hypothesis generation in quantitative studies to explain the phenomenon (DiCicco-Bloom & Crabtree, 2006).

Semi-structured interviews are usually scheduled in advance and focus on previously drafted open-ended questions. Interviews can be conducted individually or in focus groups and the time range for the interviews to be completed runs from 30 minutes to several hours (DiCicco-Bloom & Crabtree, 2006).
Semi-structured interviews have been used widely in health research. Usually, the main study research question serves as the main question of the interview. Once the interviewing process starts, new questions can be added or deleted depending on whether the questions are helping to edify the main research question (DiCicco-Bloom & Crabtree, 2006).

The strength of this method is that researchers can explore the phenomenon of interest in-depth directly from the people experiencing the issue or phenomenon. Some of the challenges of this method are that the audio recorder may fail, there may be unintelligible sections in the audiotape, or the recording of background noise could make the transcription process more difficult. Also the transcription and data analysis take longer than quantitative data analysis (DiCicco-Bloom & Crabtree, 2006). To avoid these challenges the interviews were arranged to take place in a private office, the researcher carried extra batteries for the recorder, and the recording device was placed in close-proximity to the participant.

Semi-structured interviews do not follow a fixed structure. They use open-ended questions that are focused on the area of interest of the researcher (Britten, 1995). In-depth, semi-structured interviews usually cover a few topics in detail, using the main research question as the starting interview question. The subsequent items consist of probing and clarifying questions (Britten, 1995).

Questions in semi-structured interviews are often focused on the following six areas: behavior or experience, knowledge, feelings, opinion or beliefs, sensory, and background and socio-demographics having core questions defining the areas being explored by the researcher of the study (Britten, 1995).

The semi-structured interview guide for this study has four thematic areas: stress and stress-coping mechanisms, depression, friends and family, and health beliefs and practices. The
items shown below highlight some of the main interview-guiding questions that each component of the interview used. The interviews lasted about an hour, but it could always be extended longer depending of the participant’s responses. Please see Appendix A for a detailed list of the interview-guiding questions.

**Stress and stress-coping mechanisms interview guiding questions:**

In what ways does the stress of living with HIV/AIDS affect your life?

In what ways does daily stress of living affect your living with HIV/AIDS?

What do you do to lower your stress levels?

**Depression interview guiding questions:**

Have you heard that people living with HIV/AIDS feel depressed? [Can you elaborate more?]

How do people express their depression feeling?

Are you taking any depression medication? [If so, can you tell me more about it?]

**Friends and family interview guiding questions:**

How often do you go out to have fun?

With whom do you go out?

How has living with HIV/AIDS affected your relationships?

Do family/partner/friends know your status?

Support you?

**Health Beliefs and Practices interview guiding questions:**

What is your main health concern?

What do you do to stay healthy?

Do you feel more vulnerable to sickness or illness? [Why?]
3.5.3.1 Application process of the in-depth semi-structured interview

The individual semi-structured interview took place in a private office at the community-based clinic where participants will be recruited. The office is away from the main lobby, as well as outside of heavily transited areas, increasing privacy and confidentiality.

As shown in figure 6, the interview process directly follows the participants’ signing of the informed consent. The first part of the interview is the demographic section followed by the main questions of the interview guide. Each question contains probes that can elicit new questions related to the topic, enriching the content and interview process (i.e., *You mentioned to me that you feel more vulnerable to get sick, can you give me some examples of situations that you have felt vulnerable? Has it been a situation where you have not felt vulnerable?*).

After completing the stress-related section, the interviewer paused the recording and the interview process to give a 7-minute break in order to apply the BDI-II scale and take notes about the information collected so far from the interview. The Self-reported depression scale is then conducted to give continuity to the interview content because it is at this point when the interview will transition to address the stress and mental health questions. Once the interview is completed, the investigator creates a file for the information without including the participants’ name or any other personal information that can lead to their identification. Finally, the researcher adds observations and notes to the participant’s file about any non-verbal behavior observed during the course of the interview. The participant’s contact information was saved in a password-protected file, and their files were stored in a locked cabinet to which only the investigator has have access.
3.6. Researcher’s Experience

Conducting the dissertation research was one of the most important learning experiences in the researcher’s professional development. The researcher expanded important analytic research and grant management skills that has been able to incorporate into different research projects that he is currently involved. In addition, the experience of coordinating a NIH-funded research project has proved invaluable.

Before the start of the data collection process, the researcher visited the research site 3 times to meet with clinical staff, the physicians, and the administrator of the center. At those meetings, the researcher explained the purpose of the study and the importance that each member of clinic had in the recruitment process.

The researcher was assigned a private office at the study site to conduct the interviews. The office was spacious and contained a locked file cabinet where I stored the interviews and materials used in the study. I was the only person at the clinic with a key for that file cabinet. This helped increase the security and privacy of the information.

Once everything was set-up at the clinic, the recruitment and interviewing process began. The researcher set office hours for three days a week and by appointment. The HIV/AIDS clinic staff was in charge of recruiting and referring participants to the researcher. The department of Case Management referred most of the participants, followed by the clinical staff. Physicians’ participation in the recruitment process was minimal.

The researcher attributed the recruitment referral process to the fact that case workers are the staff members in charge of providing the clinic’s clients with a more holistic healthcare service. They are in charge of enrolling participants in available assistance programs and grants to help pay for their HIV/AIDS and non-HIV/AIDS medications along with: their transportation,
food, housing, legal, and mental health services, among others. Caseworkers are more aware of the biopsychosocial situation of the client in comparison to the physicians and the rest of the clinic’s staff.

A notable barrier arose early in the study when recruitment rates proved very low. The researcher was receiving two-to-three referrals per week; and some of the participants being referred did not meet the eligibility criteria. Some factors that can be attributed to this low recruitment rate include the clinic staff’s heavy workload as well as the staff’s tendency to forget about recruiting and referring participants (largely because of the relative novelty of the study).

These issues were solved by creating a daily schedule and printing out flash cards with the eligibility criteria for the clinic’s staff. During the data collection phase, the researcher was attending the clinic every day from 8:00 am to 7:00 pm, with the exception of the days that the researcher had to return to campus for class hours. Those days the researcher went to the clinic right after classes.

Becoming more actively involved at the clinic and staying for longer periods of time helped reduce recruitment issues. First, similar to any member of the clinic, the researcher was attending recurring seminars about HIV medications and new drugs as well as to social events that the clinic was hosting. This helped the clinic staff become more familiarized with the researcher and consider him as part of the clinic and the team. The researcher started receiving more referral appointments as well as walk-in participants, who wanted to participate in the interview the same day they were invited, without a previous appointment.

Many participants decided to schedule their interviews on a day where they would have to return to the clinic for follow-up appointments, such as blood work, doctor’s appointments, medication pick-up, and case worker appointments, among others. This type of scheduling
resulted in a more effective way to recruit participants rather than scheduling at times when they did not have to go to the clinic – which, in many cases, resulted in cancelations or absenteeism.

Another barrier we found during the recruitment process was the personnel rotation of the clinic. About 50% of the clinic’s staff changed during the time collecting data. The constant change of the clinic’s staff delayed the recruitment process because the researcher needed to set times to explain the study and the inclusion criteria to the new staff members. Also, there was a period of delay while staff first adapted to their new daily job requirements before they felt comfortable adding additional duties, like the recruitment of study participants. In addition, new staff spent many days of the week in training without having access to patients. This dramatically increased the workload of the staff who were not in training, decreasing recruitment numbers.

During this time, a major HIV/AIDS care provider in the city closed their doors. This increased the clinic’s patient population and the workload of the clinical staff. In order to address this issue, flyers and posters were created and displayed in different parts of the clinic. This step proved very important because many participants who were interested in the study asked the clinic staff for more information, which increased the number of referrals and took some of the burden off of the clinical staff.

During the interview process most of the participants were calm and friendly. The researcher developed a good level of rapport with some of the participants by the time we were finished reading the informed consent. The researcher read the informed consent along with the participant to ensure they understood everything stated within it and he included some pauses as well in order to ask participants for feedback and questions about the sections included in the informed consent. These steps were very useful for all participants, regardless of their reading skills or education level.
Rapport was achieved with most of the participants by the end of the administration of demographics form. The form was included at the beginning of the interview and was read out loud to the participants instead of simply giving them the form to fill out. This was a very important step because participants became familiarized with the interview process at this point and seemed to be more comfortable and relaxed by the time the interview questions started.

At all times during the interviews, the researcher strived to maintain a sense of neutrality regardless of the information the participants reported. It was important to be empathic about the situations they have experienced, but it was equally important to never reinforce or disapprove any statements or comments the participants were reporting as it could provoke those participants fabricate or leave out information to please the interviewer.

The majority of the time, the interview process triggered several mixed emotions. The researcher felt frustration, sadness, and unfairness regarding some of the situations that the participants went through. It was also difficult to see the depression and despair of living with HIV/AIDS. Other times, the researcher experienced feelings of hope and inspiration to see how the participants had overcome adversities as to how their life experiences were used as an empowerment tool to shape and control their healthcare.

During the seven-minute break of each interview (while the BDI-II was being applied), the researcher was able to make quick notes and memos about the interview. Further notes were added to participants’ files at the end of the interview process. All notes, forms, and audio recorders were stored away in the locked cabinet before the following appointment arrived.
3.7. Data Analysis and Synthesis

Collected information was analyzed following the phenomenology tradition and techniques described previously in this chapter. The researcher also utilized different data analysis tools and software to interpret information collected. The following sections will describe the data analysis process and the different software involved in the data analysis from this study.

3.7.1. Qualitative component of the study

The recorded in-depth semi-structured interviews were fully transcribed using F4 transcription software (Marburg, 2013). F4 is a free, online program that allows the researcher to play, pause, slow down or speed up audio files, making the transcription process easier. The software has a feature that can stop and rewind the last 4 seconds of the audio file by only pressing the F4 key on the computer. One can also use that feature using a foot pedal sold by the company. The F4 features are very useful to speed up interview transcriptions, especially those which contain dialogues that are difficult to understand or contain background noise. The software also provides the option to save the transcribed interview files as Rich Text Format files (RTF), a format that most text-processing software can open and use.

The next step in the qualitative data analysis process was to upload all transcribed interviews into Atlas.ti v. 7.0 qualitative text analysis software (Germany, 2013). Atlas.ti allows the investigator to save, create, and open hermeneutic units (databases) where transcribed interviews can be stored and accessed all at once. Once the database is created, the investigator began the coding process using different types of codes and colors, as well as highlighting quotes. Atlas.ti can not only code transcriptions, but also photos, audio, and video files. The
researcher can then retrieve the codes containing the information of interest, link a code with another code, or with a note about observed behaviors, or memo that can be created with the software.

All transcribed interviews from the study were coded and analyzed using Atlas.ti. No translations were carried out from Spanish or English interviews. They were transcribed and analyzed in the original language. This process helped minimize translation or contextual errors.

After selecting phenomenology as the approach to analyze the data and then bracketing off the researcher’s experience in the field, the following step was to carefully review and read each interview in full and select the information that evoked the participants’ experience of the phenomenon. By using a process of analysis called the NCT model and it stands for noticing things, collecting things, and thinking about things. This model was developed by Susanne Friese (2011), where she states that qualitative analysis is similar to a big puzzle and the more you clean, organize and code the information, you will be able to see the better picture, which in this case is the experience of the sample population.

3.7.2 The Code-Recode, Paths, and Emerging Categories Process

During the first phase of the coding process, and after fully reading three random interview transcripts from the sample, the first preliminary list of codes was created. The list contained 78 codes containing different excerpts of information that could explain the participants’ experience of living with HIV/AIDS. Some examples of such codes are: Fat, Chips, Sadness, Stress, Age, Placeborn, and Diagnosis.

The following step involved coding all interviews using the 78 codes created on the random review as a baseline. By the end of interview five a total of 123 codes were created. The
majority of the codes created at this point overlapped with one another or contained similar information. As such, the researcher decided to merge and re-code the information that shared similar content. This process is known as the code-recode process.

There were a total of 84 codes resulting from the code-merging and cleanup process. The second phase of the analysis consisted of verifying all the transcripts for accuracy using the new codes and the information contained in them. After this, the researcher started reviewing and recoding the surveys in sets of three. The researcher kept track of any changes in the existing codes, as well as any new codes that were created. By analyzing transcripts in sets of three, the re-code process was more efficient and was easier to add, edit, or merge any code. This proved much more efficient than waiting until the recoding of 40 interviews to make the changes.

Once all interview transcripts were coded, another round of code reviewing was conducted to ensure that the codes edited in the previous sets of transcripts were also added and edited in the initial sets. During all the coding process, the researcher created electronic memos on Atlas.ti to remember the rationale and reasoning behind the merging or adding of new codes, exploring possible patterns, or to separate information that could be used at different points of the analysis. The Atlas.ti memos are similar to small electronic notepads where the researcher can make notes and attach them to a code or text in the transcript.

At this point in the analysis, a total of 66 codes resulted from the previous steps (please see Appendix C for the list of codes). The third phase of the analysis consisted of grouping the information contained in the codes and searching for patterns, relationships, and themes emerging from the data. In the previous phase, the codes were merged together if they represented the same piece of information; but, in this step of the analysis, the grouping of codes refers to different codes containing different information with similar conceptualizations. For
example, “reducing fat intake”, and “reducing carbohydrates intake” in their (participants’) meals. The quotes contained in the codes of the Atlas.ti Hermeneutic Unit (database) were retrieved using the “Query Tool” and “Quotations” options. By using both options, the researcher was able to obtain brief and detailed information about the quotes and their references and take a closer look into the quotes. Appendix D shows an example of both options with the information contained in each of them. At the end of the grouping process the researcher came-up with a list of subcategories that became the core of the main categories or themes (see Appendix E for a detailed list of subcategories). At the end of the analysis, it was determined that data saturation was reached on interview transcript 35.

The previous phases of analysis elicited 12 emerging themes that participants reported with frequency during the interviews. These themes are: Depression, Stress, Stress-Coping, Health Beliefs, Support, Health Practices, Substance Use, CAM Practices, Stigma, Cross-Border Healthcare, and Violence. There was also another theme named Unclassified, this theme was a temporary theme created by the researcher to include information considered important but where there was still not a clear decision as to which theme they belonged. Before going further in the analysis of the emerging themes, the researcher needed to confirm if the themes represented the experience of the participants and not the researcher’s biased interpretation.

Phase four consisted of assessing the trustworthiness of the analyzed information. This process was conducted using researcher triangulation (Krefting, 1991; Shenton, 2004). The process consisted of having another researcher analyze several interview transcripts and provide feedback to the main researcher regarding the codes, patterns, and themes observed in the interviews. The secondary researcher then compared their impressions with the primary
researcher’s codes, patterns, and themes (for more information about trustworthiness please read section 3.9).

Two faculty members from the college of Health Sciences/School of Nursing collaborated with the main researcher in reviewing three random interviews and provided the researcher with feedback in two primary areas. First, they commented on the emerging themes they observed in the interviews. Secondly, they compared interpretations on codes and patterns used for the analysis for those three interviews. One of the faculty members has a strong quantitative background and experience on the areas of sexually transmitted infections and the other faculty member has a strong qualitative background as well as a vast experience in conducting research with HIV/AIDS populations.

The first faculty member’s feedback was primarily focused in analyzing the emerging themes that were recurrent and emphasized by the participants in the interview transcripts. The faculty member identified the following themes in the interviews: Substance Use, Intimate Partner Violence, Behavior Change, Stigma, Stress, and Social support. These themes were the same or were included under the themes the main researcher found. For example, Social support was included under the researcher’s Support themes, Intimate Partner Violence was included under the researcher’s Violence theme, and Behavior Change under the Health Practices theme.

The second faculty member’s feedback was more in-depth and included a review of the codes, patterns, and themes. Three one-on-one meetings were schedule to review the accuracy of the data. In the first meeting, the emerging themes were discussed. The faculty member identified the following themes on the interview transcripts: Depression, Partner Violence, Stress, Health Beliefs, Healthcare Practices, Alternative Medicine, and Stigma. The themes identified by the second faculty member also matched the themes found by researcher. This
helped corroborate that the data was being analyzed accurately and that there was no researcher bias involved.

The second meeting involved reviewing the themes, subcategories, and codes. The faculty member and the researcher spent about two hours and thirty minutes reviewing the information and the structure of each theme and category to develop a visual representation of them. Finally, the last meeting addressed merging themes together. The researcher and faculty member agreed that categories such as CAM Practices, Substance use and Cross-Border Healthcare should be all part of the Health Practices theme. Stress, Depression, and Stress Coping were merged under one category called Mental Health. Violence was merged with Support, Stigma with Health beliefs, and the Unclassified themes were carefully analyzed and appropriately redistributed among the other themes. At this point in the analysis, four main themes emerged while moving to the next phase of the analysis: Mental Health, Health Beliefs, Health Practices, and Social Support. Each of these themes were supported by different subcategories described in the results section.

3.7.3. Quantitative Component of the Study

The BDI-II results were analyzed using SPSS v. 19 (Chicago, IL). Descriptive statistics of the scores were performed to describe the Self-reported depression levels of participants as well as the classification of the depressive symptomatology based on the different dimensions of the BDI-II. Descriptive statistics were also conducted to analyze the self-reported levels of depression and demographic information such as age, education level, time on ARV, and time living with HIV/AIDS, among others.

Finally, demographic information was analyzed using both Atlas.ti (described above) and SPSS, a well-known statistical software used to enter, manage, and statistically analyze
collected data. The open-ended questions included in the demographic form were transcribed and uploaded into Atlas.ti; and, the closed-ended information in the demographic form was analyzed with descriptive statistics using SPSS software.

3.8. Ethical considerations

People living with HIV/AIDS are considered a vulnerable population. Social stigma associated with HIV infection is one of the main ethical considerations when conducting research with HIV-positive individuals. People who are HIV-positive often refuse to participate in studies mainly for fear of having their status disclosed (Stein et al., 1998).

Many ethical issues arise when HIV-infected persons participate in clinical trials for new medications and vaccine development. Some examples of these ethical issues include coercion by healthcare providers when their clinics are doing any type of clinical trial or research study and potential exploitation if the person is part of the homeless or impoverished population. (Faden & Kass, 1998). Also, there is the issue of beneficence. For example, some clinical trials have a placebo group and deny treatment if the participant becomes eligible or needs it during the course of the research. Much controversy exists as to whether or not participants receive any worthwhile benefits from participating in such studies (Milford, Wassenaar, Slack, 2006).

The protection of human subjects in research is one of the primary duties of Institutional Review Boards (IRB), which are committees formed to review that studies follow ethical standards and provide oversight to ensure the rights and welfare of participants are protected (Coughlin, 2006). This study is part of a bigger research grant focused on adherence to HIV/AIDS medications. Approval for this study was granted by the UTEP IRB board (#499867-1).
The informed consent form was offered in English or Spanish, depending of the participant’s language of preference and covered the following main areas: study purpose, who is conducting this study, possible risks and discomforts of the study, the cost and benefits, confidentiality, contact information for the researcher and university, withdrawal process, and a mandatory reporting clause. To read the main study’s informed consent refer to Appendix B.

Participants were asked if they had any questions about the form and clarity concerning the informed consent was established. Special emphasis was placed on the areas of confidentiality and withdrawal, making very clear that participants could avoid responding to any questions that they feel uncomfortable answering, and that they could withdraw from the study at any time. If they decided to do so, any information collected was destroyed.

Participants were provided with a copy of the informed consent in order to provide contact information from the researcher and UTEP’s IRB office. Additionally, should a question arise after their participation in the study, they can freely contact the researcher or the university’s IRB office.

Any analysis of the information was conducted as a unit, without any information that can lead to the identification of a participant. The participants’ study files do not contain the participants’ names or information that can directly identify them. All forms and files have an alphanumeric code representing participant’s identification number, which were stored separately from the participants’ contact information. All files were kept in a locked cabinet and interviewer/researcher was the only one with access to it. Any electronic file was password protected to increase security of the information.

3.9. Overview and Implementation of Trustworthiness
Trustworthiness is the term that defines the credibility and validity of a qualitative research study and it consists primarily of four main areas: credibility, transferability, dependability, and confirmability (Krefting, 1991).

Shenton (2004) defines credibility as the logic and congruence of the research findings with reality. It is important to ensure that results and conclusions accurately describe the participants’ perspective and the representation of the phenomenon. To assess credibility, first the researcher needs an appropriate and recognized research design and method. In this case, the study is based on the hermeneutic phenomenology tradition, which is one of the most used and recognized traditions in qualitative research in the health sciences and nursing field.

Other methods that were implemented in this study to ensure credibility are: a) becoming familiarized with the culture of the participating organization (the clinic) to establish a sense of trust and collaboration between the clinic staff and the researcher. Shenton (2004) suggests visiting and meeting the staff before the data collection process starts to gain their trust and willingness to collaborate in the study. This is method proved very useful for this study because the community-based clinic staff will be responsible for recruiting participants and referring them to the researcher; b) triangulation of the data collection methods was performed (semi-structured in-depth interviews, notes, observations, scales, and forms), as well as researcher triangulation. Triangulation is one of the most often used methods to ensure credibility in qualitative research (Krefting, 1991; Johnson, 1997; Whittemore, Chase, & Mandle, 2001; Shenton, 2004); c) interviewing skills are important to ensure credibility because they can facilitate rapport and trust with participants that may in turn feel more comfortable to share more information about their experience of living with HIV/AIDS (Krefting, 1991; Shenton, 2004); d) debriefing sessions between researcher and supervisor are important to increase credibility of the
study because it can detect flaws (such as implementing questions that will increase the understanding of the phenomenon, add more probes, interviewing strategies, detection of biases, etc.) that can be prevented at an early stage and fixed (Shenton, 2004); e) examination of previous research is an important method because it can check how congruent the findings are with the previous studies on Latinos living with HIV/AIDS (Whittemore et al., 2001; Shenton, 2004).

Transferability is defined as how the research finding can be applied (or transferred) to other situations and contexts (Lincoln & Guba, 1985). Some strategies and methods that were implemented in the study to increase transferability are: implementing extensive background information about the contexts and the participants in the study, and providing detailed demographics of the sample. This will allow other researchers to make comparisons about the study and its findings (Krefting, 1991).

Dependability is defined as the ability to obtain similar results if the research was to be replicated under the same context, methods, and participants. Some strategies to achieve dependability in this study are firstly an in-depth description of the methodology of this study to allow other researchers to repeat the study. Triangulation also plays an important role in dependability using different data collection methods (overlapping methods), code-recode procedure (code and re-code the same transcript days after), and investigators’ triangulation to corroborate the pattern of the results (Krefting, 1991; Shenton, 2004).

Finally, confirmability refers to ensuring that the research findings are the result of the experience of participants with the phenomenon being studied. Some strategies that will help assure confirmability in this study are: 1) in-depth description of the methods section to demonstrate the integrity of the study; 2) audit strategy: this consist of an external person to be
able to follow the study step by step and be able to understand the decisions and analysis-made diagrams and visuals describing the steps are being included in this proposal to facilitate this process; and 3) Triangulation to reduce researcher bias and data collection methods weaknesses.
STUDY FINDINGS

Results from this study were guided by a phenomenological approach. The study explored the lived experiences of LMSMLHA regarding social determinants affecting their mental health, particularly their reported health beliefs and practices. The study explored the participants’ lived experiences based on six categories (themes) that emerged from the data analysis.

This chapter is divided in four sections. First, the researcher will provide a description of his experiences in conducting this study, including the integration into the clinic’s culture, the recruitment process, and the interviewing process. The second section will describe the participants’ demographics. The third section consists of a detailed description of the created codes. The final section of this chapter provides a detailed description of the patterns, subcategories and themes that emerged from the participants’ experiences.

4.1 Participant Demographics

Forty, semi-structured, in-depth interviews were conducted with HIV-infected MSM who received healthcare at a community-based clinic located in a city on the U.S.-Mexico border. Each interview lasted for about an hour and half. There were some interviews that lasted longer than two hours. All interviews were conducted a La Fe clinic, with the exception of two participants who opted to use a different location due to work and health problems. One participant decided to conduct the interview at a public library while the other chose his home. Tables 4 and 5 give a more detailed description of the sample demographics.

Table 3: Participants’ Demographics.
Participants
Demographics

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Participants</th>
<th>Range</th>
<th>Minimum</th>
<th>Maximum</th>
<th>$\bar{x}$</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time in El Paso</td>
<td>33</td>
<td>3 months</td>
<td>49</td>
<td>49</td>
<td>15.66</td>
<td>±14.6</td>
</tr>
<tr>
<td>Age</td>
<td>40</td>
<td>27 years</td>
<td>69</td>
<td>69</td>
<td>44.91</td>
<td>±10.65</td>
</tr>
<tr>
<td>Education</td>
<td>40</td>
<td>2 years</td>
<td>16</td>
<td>16</td>
<td>11.84</td>
<td>±3.79</td>
</tr>
<tr>
<td>Time with HIV</td>
<td>40</td>
<td>3 months</td>
<td>27</td>
<td>27</td>
<td>9.26</td>
<td>±7.33</td>
</tr>
<tr>
<td>Time with ARV</td>
<td>31</td>
<td>3 weeks</td>
<td>20</td>
<td>20</td>
<td>7.86</td>
<td>±5.48</td>
</tr>
<tr>
<td>BDI-II Scores</td>
<td>40</td>
<td>0 points</td>
<td>49</td>
<td>49</td>
<td>13.33</td>
<td>±11.58</td>
</tr>
<tr>
<td>Self-reported</td>
<td>40</td>
<td>1 point</td>
<td>10</td>
<td>10</td>
<td>5.82</td>
<td>±2.67</td>
</tr>
<tr>
<td>Stress Level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The majority of the participants reported the city of El Paso, TX as their place of residence (82.5%). The length of time that participants reported to have lived in El Paso ranged from three months to 49 years, with a mean of approximately 15 years ($\bar{x}=15.66 \pm 14.6\text{ years}$) at the time the interviews were conducted. The remaining 17.5% of the sample reported living in cities adjacent to the area of El Paso - specifically Las Cruces, NM and Ciudad Juarez, Mexico.

Participants’ ages ranged from 27-69 years and the mean age of the study sample was 44 years old ($\bar{x}=44.91 \pm 10.65\text{ years}$). About one third of the sample (32.5%) reported during the interview to be born in El Paso, 37.5% reported they were born in Ciudad Juarez, and 25% in other parts of Mexico. The rest of the sample reported being born in the United States.

The education level of the participants ranged from two to 16 years (college education). The majority of the sample ranged from 12-16 (47.5%) years of education and the sample mean was approximately 12 years ($\bar{x}=11.84 \pm 3.79\text{ years}$). Many participants reported having a college degree or some college education. Also, one participant mentioned receiving their General Educational Development (GED) degree.

Regarding time living with HIV/AIDS, the sample ranged between three months to 27 years. The mean of time living with HIV/AIDS was approximately nine years ($\bar{x}=9.26 \pm 7.33$
years). This timeframe was estimated based on the year the participant reported finding out about their HIV-positive status.

Table 4: Demographics of study participants

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Participants (N=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
</tr>
<tr>
<td><strong>Time in El Paso</strong></td>
<td></td>
</tr>
<tr>
<td>Not in El Paso</td>
<td>7</td>
</tr>
<tr>
<td>3mo to 12 yrs</td>
<td>16</td>
</tr>
<tr>
<td>13 to 24 yrs</td>
<td>7</td>
</tr>
<tr>
<td>25 to 37 yrs</td>
<td>4</td>
</tr>
<tr>
<td>38 to 49 yrs</td>
<td>6</td>
</tr>
<tr>
<td><strong>Age range</strong></td>
<td></td>
</tr>
<tr>
<td>27 to 41 yrs</td>
<td>16</td>
</tr>
<tr>
<td>42 to 55 yrs</td>
<td>15</td>
</tr>
<tr>
<td>56 to 69 yrs</td>
<td>9</td>
</tr>
<tr>
<td><strong>Birth Place</strong></td>
<td></td>
</tr>
<tr>
<td>El Paso</td>
<td>13</td>
</tr>
<tr>
<td>Juarez</td>
<td>15</td>
</tr>
<tr>
<td>New Mexico</td>
<td>1</td>
</tr>
<tr>
<td>Mexico*</td>
<td>10</td>
</tr>
<tr>
<td>U.S.**</td>
<td>1</td>
</tr>
<tr>
<td><strong>Years of Education</strong></td>
<td></td>
</tr>
<tr>
<td>0 to 6 yrs</td>
<td>3</td>
</tr>
<tr>
<td>7 to 12 yrs</td>
<td>18</td>
</tr>
<tr>
<td>12 to 16 yrs</td>
<td>19</td>
</tr>
<tr>
<td><strong>Time Living with HIV/AIDS</strong></td>
<td></td>
</tr>
<tr>
<td>3 mo to 7 yrs</td>
<td>19</td>
</tr>
<tr>
<td>8 to 14 yrs</td>
<td>12</td>
</tr>
<tr>
<td>15 to 21 yrs</td>
<td>5</td>
</tr>
<tr>
<td>22 to 27 yrs</td>
<td>4</td>
</tr>
</tbody>
</table>

* Participants who were born in Mexico but in a different state than Chihuahua
** Participants who were born in the United States but in a different state than Texas or New Mexico
Table 4: Demographics of study participants (Continuation).

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Participants (N=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
</tr>
<tr>
<td><strong>Time on ARV</strong></td>
<td></td>
</tr>
<tr>
<td>Not on ARV</td>
<td>8</td>
</tr>
<tr>
<td>2 wks to 5 yrs</td>
<td>13</td>
</tr>
<tr>
<td>6 to 10 yrs</td>
<td>9</td>
</tr>
<tr>
<td>11 to 15 yrs</td>
<td>6</td>
</tr>
<tr>
<td>16 to 20 yrs</td>
<td>4</td>
</tr>
<tr>
<td><strong>Border Crossing</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
</tr>
<tr>
<td>No</td>
<td>25</td>
</tr>
<tr>
<td><strong>BDI-II</strong></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Minimal</td>
<td>13</td>
</tr>
<tr>
<td>Mild</td>
<td>15</td>
</tr>
<tr>
<td>Moderate</td>
<td>1</td>
</tr>
<tr>
<td>Severe</td>
<td>10</td>
</tr>
<tr>
<td><strong>Relationship Status</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>30</td>
</tr>
<tr>
<td>Not Single*</td>
<td>10</td>
</tr>
</tbody>
</table>

* Includes participants who were partnered, involved in a long-term relationship, or seeing someone

From the entire study sample, 80% were currently under some type of ARV treatment regime and about 20% of the sample reported they were not currently, or never had been on ARV treatment. The range of time on ARV treatment in which most of the sample was included was from two weeks to five years. The mean length of time on ARV medication was 7.86 ± 5.48 years.

Border crossing was an important part of the study participant’s social and self-care behaviors. More than 30% reported crossing the U.S. border into Mexico to visit family and friends, as well as to obtain complementary healthcare, including: the treatment of opportunistic
infections, antibiotics, complementary and alternative medicine such as herbal supplements and teas, and even HIV/AIDS medications.

The sample’s self-reported depression scores (BDI-II) ranged from zero to 49, with a mean score of 13.33 ± 11.58. The BDI-II has four categories to define the different levels of depression. These categories are minimal (0-13), mild (14-19), moderate (20-28), and severe (29-63). The majority of the participant’s scores fell under the minimal and moderate depression symptoms categories.

Finally, the majority of the interviewed participants in the sample reported their relationship status as single (80%) and the remaining participants reported their status as “not single.” The “not single” category includes participants who were partnered, involved in a long-term relationship, or seeing someone.

Table 5: Distribution of Self-reported depression treatment.

<table>
<thead>
<tr>
<th>BDI-II categories</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Mild</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>Moderate</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Severe</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>Not in treatment</td>
<td>28</td>
<td>70.0</td>
</tr>
</tbody>
</table>

Table 6: Self-reported stress levels.

<table>
<thead>
<tr>
<th>Stress Levels</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>10</td>
<td>25.0</td>
</tr>
<tr>
<td>4-6</td>
<td>14</td>
<td>35.0</td>
</tr>
<tr>
<td>7-9</td>
<td>12</td>
<td>30.0</td>
</tr>
<tr>
<td>10</td>
<td>4</td>
<td>10.0</td>
</tr>
</tbody>
</table>
4.2. Emerging Themes

Four major themes (Mental Health, Health Beliefs, Health Practices, and Social Support) emerged from the data analysis in relation with the specific aims of this study, which are 1) To explore the level of Self-reported depression that the participant sample report; 2) the experienced social determinants affecting the participants’ level of stress; 3) the health beliefs and practices participants reported using to maintain health; and 4) the behavioral strategies these men use to reduce their stress levels. The following section is organized thematically, including respective subcategories.

4.2.1. Mental Health

This theme is organized around four subcategories, depression, stress, stress-coping mechanisms, and suicidal thoughts. The first subcategory explores the participants’ experience with depression and how it has impacted their life. The second subcategory explores the participants’ experience with stress - how they perceive stress is affecting their health and daily activities. The third subcategory is focused on the coping strategies that participants use to cope with stress and the fourth subcategory describes how some of the participants reported having suicidal ideations due to the constant depression and stress that they experience on a daily basis. The last category refers to other important emotional factors affecting the mental health of the participants, which are outside the realm of depression and stress.

4.2.1.1. Depression

Depression is one of the themes that appeared with high frequency among the analyzed transcripts. All participants reported being diagnosed with depression at different points of their
life after becoming infected with HIV/AIDS, and the majority reported to still being struggling with some levels of depression. This was also confirmed by the BDI-II self-reported depression scale (see Table 4). The following quotes describe some of the participants’ experience with depression. The first quote is from a participant that became depressed when he started noticing changes in his body due to the HIV/AIDS medication side effects:

Vaya pues con sus consecuencias [Medicamento para el VIH] ¿no? el, el hígado, los ojos amarillos, que de repente se me pusieron muy, muy amarillos, y como te vuelvo a repetir eso me ponía muy, muy deprimido.

[Well, I think it was a consequence of my (ARV) medication isn’t it? The liver, the yellow eyes, they turned very, very yellow all of a sudden, and as I said before, that made me very, very depressed.]

The same participant also mentioned how depression affected his self-care behaviors to the point that he decided to suspend his ARV medication:

Por depresión, porque dije: ya no, ya no las voy a tomar [medicamento para el VIH], estoy sano y estoy bien.

[Because of the depression, because I said to myself, “that’s it, I’m not going to take those (ARV medications), I am healthy and I am good]

The next quote is from a participant who, at the time of his interview, was just moving back to El Paso. He shared his experience of how depression was affecting his life:

Um like I said my depression and anxiety…back in Orlando I would just have two or three days where I just didn’t want to get up out of bed and I was just depressed that I had this [HIV]. When I first found out I was like, “Oh my God, I’m gonna die. (laughs) I’m
gonna die tomorrow and that’s gonna be the end of it.

Another participant shares how the recent loss of his job affected him to the point of developing severe depression that is not only affecting his daily activities but also his sleep:

Si, tengo ese problema [depresión] fuerte, fuertemente. Haz de cuenta que ahorita atravieso por una situación muy difícil, perdí mi trabajo a raíz de la recesión, no tengo trabajo tres meses de enero para acá, no hay, no hay en la plaza trabajo, y normalmente tengo mucha estrés y mucha depresión, paso noches sin dormir.

[Yes, I have that problem (depression) very strong. You know, right now I am going through a very difficult situation, I lost my job due to the recession, and I have not had a job in three months. Since January until now, there are no jobs, and I am always having lots of stress and depression, I spend many nights without sleep.]

From all interviewed participants, only 30% reported to be on antidepressant medication, and from that 30%, several participants mentioned that they continued to struggle with depression. This was confirmed by the results from the BDI-II self-reported depression scale. For more detailed information about the distribution of the depression levels, please see tables 4 and 5.

The following quotes describe some of the participants’ experience with antidepressants. The first one is from a participant who had been struggling with depression for about two years:

…Two years. I’m going through Depression right now I’m taking Effexor [you are taking medications?] yeah for the depression (sobbing).

Another participant who, at the time of the interview, was on antidepressants describes how depression has been affecting his willingness to be in a relationship:
I'm depressed, and of course, right now I'm not interested [in having a relationship]. It's the last thing I have in my mind but depression made me lose interest.

The following quote is from a participant that mentioned to the researcher that he believes that his difficulty with depression was because he was told by healthcare providers to take his antidepressants in a wrong way:

Y mañana, no el, el día quince tengo una cita con, con la psiquiatra y le voy a decir que… y es que le digo es culpa también de los psiquiatras porque ella apenas tengo poco que me está tratando, y ella si me había dicho que me lo tome regularmente siempre, que me lo tome, y los otros psiquiatras que yo consideraba que… más tiempo ahí en esa clínica, mas, con más edad, y ellos me decían que estaba bien como me lo tomaba, que me lo tomara nomas cuando creía yo que lo necesitaba, tres psiquiatras, cuatro con uno que, que ese, ese me dio otra medicina que era para dormir.

[And tomorrow, no, the 15th I have an appointment with the psychiatrist and I am going to tell her… and I am telling you that it is also the psychiatrist’s fault, because she just started treating me, and she told me to take it always regularly (antidepressant), and always to take it, because the other psychiatrists that I thought were (good)…because of the time they have working in the clinic and because of their age, I thought that they were giving me the right instructions when they told me to take it (antidepressant medication) only when I felt that I needed it. Three psychiatrists, well, four with the new one….this one gave me another medicine to help me sleep.]
4.2.1.2 Stress

Stress plays an important role on the emotional health of the participants interviewed. Many participants reported living under considerable stress, which was affecting their performance and daily activities. When the researcher asked the participants to assign a number that described how much stress they were going through on a scale from one to ten – “one” being the lowest stress possible and “ten” the highest - more than half of the participants reported a rating of five or higher. For a more detailed description of the participants’ stress please see tables 3 and 6.

The analysis showed that most participants had five primary sources of stress in common. First, income and job security was one factor that the majority of the participants reported to be their primary source of stress. This is followed by relationships (friends, family, and partner), and then healthcare and services. Participants also mentioned that violence was an important factor that increased their stress level.

The following selections will describe how the factors mentioned previously affected the stress-level of participants. The first is from a participant that, at the time of the interview, was recently diagnosed with HIV/AIDS. He mentioned to the researcher that the biggest stress he has is maintaining his current financial security:

What stresses you? Probably the financial situation, what's the near future is gonna be. It’s something that obviously affects me and I think about like how is it going to be in the next month... am I gonna have a work? Am I gonna have any projects going on? I think to a certain point it stresses me out and it's something that is constantly in my mind lately, but other than that, other than the financial situation or my future in my profession, I
don't think I have any other stress… and a big role that even made it worse, was the person that diagnosed me stressed several times that the meds are very expensive.

Another participant mentioned that being unemployed, not being able to work again are the factors affecting his stress the most in addition to feeling he may become a burden to his mother:

Well, I can't go back to work. I mean, I can, 'cause before I used to work, but I can't any more and then with my mom, and me, and, you know, what if I get sicker and she doesn't… I mean, she's still alive and she's going to have to take care of me. I don't want to do that right? But that's just the consequences that I'm going to face.

Family and relationships played an important role in the participants’ mental health status and levels of stress, the following quotes describe two cases where the participant stated to the researcher that family and relationships were an important source of increased stress:

Well I guess right now is my Mom’s health. I'm worrying too much for her and she already told me you know, that I am worrying too much and to take me some time from the hospital, that she is ok there and that I should not worry but I still worry. That’s mostly the main thing.

The next participant mentioned to the researcher that not being in a relationship was something that was generating high levels of stress:

Quizá el estar sin pareja, el estar solo. Es que me acostumbro a personas, que cuando ya no están...[¿Resientes?] Si resiento a pesar de que la mayoría del tiempo he estado solo y que me gusta estar solo pero como que debo de poner algo de atención en eso, no me puedo estar imponiendo a nadie, entonces seria eso.
[Maybe being without a partner, to be alone. The thing is that I get used to people and when they are not there … Do you feel resentment? Yes I do, even though most of the time I have been alone, and I like to be alone but I think I should pay more attention to that, I cannot obligate people to be with me, I guess that is it.]

The following quotes describe other important sources of stress to the participants – namely health related issues and the availability of HIV/AIDS healthcare. The first selection is from a participant whose primary source of stress was related to the fear of losing the State sponsorship that covered most of his medication costs. When the researcher asked about the factor that was causing him high levels of stress, he replied:

fíjate que lo que sí te afecta psicológicamente es cuando de repente estás en un programa de atención médica como el que estoy, y que hay cambios gubernamentales y te viene la psicosis de que ¡hijole! Y si te llegan a sacar? O, que va a pasar? O que bajo el presupuesto. Ese tipo de información cuando te la pasan, aunque te quieren mantener informado, psicológicamente te afecta y eso fue lo que me causo comprar una vez un kit de Combivir y de Viracept.

[What it affects you psychologically is when you are enrolled in a program of primary care like the one I am currently part of, and then some government changes come along…that kind of freaks you out. What if you lose your eligibility? What is going to happen next? What if there is budget reduction? When that kind of information reaches you, even if you want to keep yourself informed about it, it affects you psychologically. That was the reason that one time I bought a whole kit of Combivir and Viracept.]

Another participant reported how changes in his health and body affected him not only in increasing his stress but also to the point of developing depression:
De hecho, una vez que me corté, mi sangre se veía… no era la misma sangre que yo tenía antes, también eso me derrumbó. I: ¿En qué cambió? En que antes me cortaba y mi sangre era espesa, rojita, y ahora es puro ácido, puro líquido, agua; vaya, así puro líquido, puro ácido. Cambió hasta el color, y si me deprimí mucho, me derrumbe, dije: mi sangre no es la misma, no es la misma que tenía antes. Si fue muy duro.

[In fact, one time I cut myself, my blood looked…it wasn’t the same blood that I had before, that also devastated me. I: How had it changed? Before, when I cut myself my blood was thick and red, and now is pure acid, only liquid, water; only water, only acid. Even the color is different, I was very depressed and I was devastated, I said to myself: my blood is not the same, the same that I used to have. That was very hard for me.]

Another important factor that participants reported to interfere with the participants stress is the increased violence on the border. The following quote is from a participant who decreased his visits to Juarez due to the stress of getting shot by a stray bullet:

Te puede tocar un balazo perdido en una gasolinera, en un cafè, en un restaurante, en una funeraria, en un hospital. Entonces sí se eleva el estrés y también corta tu libertad de desplazarte a donde tú quieras con tranquilidad y sin estar paranoico.

[You can get hit by a stray bullet at the gas station, at a cafe, at a restaurant, at the funeral home, at the hospital. Then yes, your stress levels go up and also it hinders whatever sense of liberty you have to go wherever you want peacefully and without being completely paranoid.]
4.2.1.3 Stress Coping

Coping represents an important part of participants’ mental health. Participants reported different ways of coping with stress. Some of the most common strategies that participants used to lower their stress level are activities that require a cognitive or mental relaxation, such as listening to music, going to a therapist, reading, or following a spiritual connection. Other participants reported using activities that required primarily a physical activity, such as walking and exercising among others. Yet another way to cope with stress by participants was by ingesting medications - teas, or drugs. The following quotes describe the different strategies of coping described above. The first quote is from a participant who mentioned going to a psychologist to help him cope with the stress that he is currently experiencing:

Hace poco fui al psicólogo porque tenía mucho estrés acumulado, traía mucha carga entonces llega el momento que necesitas desahogarte con alguien más que tu pareja, porque tu pareja te apoya, pero no te entiende tu situación psicológica contra tu enfermedad contra todo eso…fui con la psicóloga, me ayudo con unos trabajos, creo que no batallo mucho conmigo porque el trabajo que hicimos fue excelente, me ayudo mucho a reconocer mis éxitos, las cosas importantes que he hecho en mi vida y es lo que me da autoestima, el conocer los grandes logros que he hecho, y lo demás viene de sobra...La vida no es de color de rosa para ganar hay que sufrir.

[Recently, I visited a psychologist because I was accumulating a lot of stress; I was feeling overwhelmed. There is a time that you need to open up to someone besides your partner, because a partner supports you, but he doesn’t understand the psychological distress that your illness and everything else is causing you… I went to a psychologist, and she helped me with some tasks, I think she did not have a hard time helping me]
because the work that we did was excellent. She helped me a lot in recognizing my success and all the important things I have done in my life, which is a sobering fact…life is not always pink, to win you have to suffer.]

Another participant mentioned that for him, one of the best ways to cope with stress is to separate from others and relax by having alone time:

Mmm, I usually will like separate myself from others. Usually just being at my apartment or not calling anyone because I don’t want to impose on anybody else, or lash out at somebody else that doesn’t need it, you know what I mean? So instead of being negative towards somebody else for no reason I usually separate myself and calm myself down, or listen to music, or just have my alone time for me to kind of…I: Do you meditate in those situations or…Um, I do. It lowers my stress. But certain things are always there like just the way the economy is right now, and like I said being put on Medicare that’s a whole new thing for me. It’s, it’s involved in a lot so…

This quote is from a participant that uses his spiritual belief system to lower his stress levels. He also likes to visit friends to talk and vent out his frustrations:

Algo muy, muy bueno, le digo: Señor ayúdame, Dios ayúdame, dame paciencia, dame paz; y agarro un libro, que antes no era de los que leía, no me gustaba leer, no leo mucho verdad pero si leo mi Biblia, leo un libro, y eso me trata, de mantenerme con el estrés bajo. El platicar con un amigo también es bueno, te baja el estrés, te baja, sacas todo lo que traes, sacas todo, todo, todo, y el que te escuchen ¿no? el que te escuchen el problemón que traes tu verdad, y que alguien te escuche, también me ayuda mucho

[I do something very, very good, I said: Lord please help me, God help me, give me patience, give me peace, and then I pick up a book, I never liked to read, I don’t read
much to be honest, but I do read the Bible, that treats my stress and keeps it low. Talking to a friend is also good, it lowers your stress and it helps you to take it all out, all that you have inside, everything, and having someone that listens to you and all your problems.

That also helped me a lot.

The next quote is from a participant that mentioned that in order to lower his levels of stress; he enjoys being active and tries to find a solution to the situation that is causing him the stress:

Yo pienso que hoy me ayuda que, me ayuda en algo el ejercicio. Otra, es me calmo y trato de analizar la situacion y buscarle la solucion.

[I think what is helping me in a way is the fact that I exercise. Also, another thing is that I try to stay calm so I can analyze the situation and try to find how to solve it.]

The next quote is from a participant that likes to go out for walks when he is feeling stressed or under a lot of pressure:

Cuando me siento presionado, salgo de la casa y camino en el parque o voy a la tienda cerca de los Del Rio, Bip Bip [Tienda de abarrotes], siento el aire, voy caminando, veo la gente que pasa, los carros, que generalmente lo hago en el parque dentro de mi casa, pero cuando me siento mal digo voy a caminar por la calle y todo eso, cortito, hace mucho que no lo hago pero estoy hablando de tiempo atrás pero ahora pues la verdad me da miedo y lo hago ahí en el parque que está en la casa, y ¿Y ayuda a bajarte los niveles de estrés?], Si, inmediatamente, y no siento yo estrés, siento como presión que quiero salir a que me dé el aire, así lo siento, no como molesto sino como sofocado y necesito salir al exterior, de mi casa a caminar.
When I feel pressured, I get out of the house and take a walk in the park, or I go to the store close to los Del Rio, Bip Bip (convenience store). I feel the air while I am walking, I see the people passing by, the vehicles; I usually do this in the park close to my house but when I am feeling bad I take a short walk on the streets. However, I haven’t done it lately because I am scared of doing it so I just walk in the park close to my house. Does that help you to lower your stress levels? Yes, immediately, I stop feeling stress, I feel the pressure leaving my body and feel the air, that is how I feel it. I need to get to out from my place and walk when I feel...not like upset, but more like suffocated.

The following quote is from a participant who mentioned to the researcher that the strategy he usually uses to lower his stress level and ARV medication side effects is to use marijuana:

I smoke weed, it helps me, it tranquilizes me, you know it’s a tranquilizer? [Yeah] (Laughs) and it also takes away my nausea because I used to get nausea from my cocktail so my doctor said “well... just keep doing it.” If it works and it’s keeping your medication (side effects) down, because otherwise it (side effects) will just come back up, you know. Another participants reported using marijuana for medicinal purpose. The following quote is from a participant that uses marijuana to increase his appetite and counteract his levels of stress and depression:

I’m not gonna lie I used to smoke marijuana and that would help with the anxiety, or the depression. But also gave me a little more of an appetite, so... I mean there are a lot of pros and cons about that, I know that. Um, that would be the only thing that I would say that I would indulge in.
The next quote is from a participant who lowers his stress levels by preparing herbal teas or by visiting a family member:

Tomar algún té especial para estrés, para nervios o salir, visitar a una hermana que, que conoce un poquito más de mi vida y que me ayuda moralmente.

[Drinking a special tea to treat stress, to stop being nervous, or I go and visit a sister who knows a little bit more about my life and helps my morale.]

### 4.2.1.4 Suicidal Thoughts

Some participants also reported that depression and exposure to constant stress negatively affected their willingness to live. Suicidal thoughts were common among the sample of men interviewed for this study. The following quotes describe how participants feel a sense of hopelessness and loss of interest in living. The first quote is from a participant who reported to the researcher that depression is causing him to think of his own mortality and giving-up on life:

Pues a veces por lo que estoy pasando [VIH] digo: hay, desearía mejor estar muerto, sería mejor ya no continuar, sería mejor..., pues tantas cosas que pasan por la cabeza de uno ósea también pienso que es por la depresión [tener esos pensamientos], a veces pienso que sería mejor ya no estar aquí, y aparte que veo a mi madre como esta y como estamos batallando con ella, se me viene la mente que así voy a estar yo en algún momento y no quisiera llegar a eso la verdad.

[Well sometimes, with what I am going through (Living with HIV/AIDS) I say to myself: oh, I wish I were dead, it would be better to stop living on, it will be better…so many things cross one’s mind, I mean I also think that it is because of the depression (to have those thoughts), but I think it will be better if I was not here. And also I see my mom and]
how she is and how are we struggling with her, it just crosses my mind that I will be like her one day and honestly I don’t want to get to that point.]

The following quote is from a participant who stated that he premeditatedly engaged in behaviors that had put his life at risk because he was overwhelmed by the situations that were affecting him emotionally:

El año pasado que decidí no tomarme las medicinas [para el VIH], yo quería que ya se acabara todo esto…de todo es estrés, de la casa y del trabajo, se me junto todo y dije saben que ya prefiero colgar los tenis. Y luego empecé a hablar con la doctora y me dijo Noo… y lo comencé a tomar otra vez [antirretrovirales (ARV)]. [¿Cuánto tiempo dejaste de tomarlo?] Como tres semanas o un mes casi.

[Last year I decided to stop taking the medications (ARVs). I wanted everything to end…of all the stress, the home, and my job, everything was building up so I said to myself: you know, I prefer to hang my boots. Then I started to talk with the doctor and she told me not to, so I started taking them (ARVs) again. How long did you stop taking them? For about three weeks or one month.]

Another participant mentioned to the researcher that even though he had not shown any self-harming behaviors (due to his religious beliefs), he had thought several times about taking his own life. The next quote describes the participant’s experience of finding out about his HIV diagnosis:

No, no, no, desde el primer momento que me dijeron de la noticia [acerca de su diagnostico], de hecho yo ya tenía tres, cuatro meses que no tomaba ni una gota de alcohol. Después de la noticia tampoco he tomado alcohol, ni siquiera una gota. A veces, al principio verdad, si me paso por la mente el suicidarme, el matarme, el estrellarme en
el carro, quitarme la vida, en desaparecer simplemente, desaparecer, pero tengo unos
principios desde chico que, que no los utilicé de grande, pero ahora estoy tratando de
utilizar que, que es la comunión con Dios, y pues no es bueno quitarte la vida
[No, no, no, since the first time that I got the news (HIV diagnosis), I had already gone
about three or four months where I did not have a drop of alcohol. After the news, I still
haven’t had alcohol, not even a drop. Sometimes, at the beginning it crossed my mind to
commit suicide, to kill myself, crash with my car, take my life away, just simply
disappear, but I have some values that I never used as an adult until now, which is to be
in communion with God, and well, it is not good to take your own life.]

4.2.2 Health Beliefs

Health topics were a reoccurring theme appearing on the participant’s interview
transcripts. The health beliefs subcategories reported by most of the participants to the researcher
are the beliefs related to HIV/AIDS and impact in the participants’ health as well as the beliefs
about the knowledge of the general population in regard to HIV/AIDS. All participants reported
that becoming infected with HIV/AIDS affected their health at different levels and in different
spheres of their life. The following section provides different quotes and examples of how
participants perceived how living with HIV/AIDS and being on ARV treatments has affected
their health, what barriers the participants believe that are interfering with healthcare seeking
behaviors, and how they believe that the overall level of HIV/AIDS education in the region is
minimal. We will also address the importance that stigma has in this population and how they
believe it affects their access to healthcare.
4.2.2.1 HIV/AIDS Beliefs

The first quote is from a participant who believes that being HIV positive affected his health performance and physical activity. He believes if his body has a faster bloodstream, the disease will progress faster:

See, that to me is changed (health), you know. And, stuff that I used to do, that won't get me tired. Like, I used to run, I used to hike. I used to do a lot of stuff, and now I don't because it's... I don't want, um, como se dice? [How do you say?] Um... To speed it up...

Que se haga produce mas pronto [To spread it faster] ... Like they say, when you get angry, they get you agitated, your bloodstream is going faster and faster and faster. It's making it more badly for you. So...

The following participant mentioned that he believed he knows exactly when he got infected with HIV due to the different symptoms he developed after a high-risk sexual practice:

Lo que sí quiero en esta grabación, si se quien me infecto, si se los síntomas, inmediatamente, que no me cuenten mentiras, el que conoce su cuerpo si sabe inmediatamente. Yo si me di cuenta inmediatamente. Supe el día que se rompió el condón y supe ya después cuando pasó, pero la persona que falleció no me había dicho que estaba infectado, yo me entere después hasta tres meses, pero el cuerpo mío, como yo nunca me había enfermado, yo no supe…entonces yo si supe inmediatamente. Dolores de cabeza, sudor, diarrea y bajo de peso. Inmediatamente. Y tengo comprobante en el 2003, tengo un comprobante muy fuerte, para mí! Viene siendo para mí, porque me acababan de hacer análisis de todo, y yo no estaba infectado. Pero esas eran unas pruebas de otra cosa, no de lo que estaba haciendo. Viene siendo, es que una historia muy fuerte,
pero tengo ese comprobante y en el 2003 en marzo para eso iniciaron esas pruebas, no estaba diagnosticado, para el 2004 de marzo ya lo tenía

[What I really want explained on this recording, is that I know who infected me, and I knew the symptoms right away. No one is going to lie to me because if you know your body, you know immediately when it happens. I did notice immediately. I knew the day that the condom broke, and knew after it happened. The person who passed away did not mentioned to me that he was infected – I knew about it three months after – but my body, cause I have never fallen sick, knew right away because I started having headaches, sweats, diarrhea, and weight loss immediately. I have had previous tests when I was not infected, so this was very shocking to me. In March of 2003 I was not infected and then by March 2004 I had it.]

Almost all the participants reported feeling more susceptible to illness and that they needed to be more careful about their healthcare than the rest of the population. The following statement is from a participant who believes that being HIV positive makes him more susceptible to illness, so he takes better care of himself and gets vaccinated for different conditions on a regular basis:

Si, la condición de uno de acuerdo a los consejos médicos si tiene uno que tener más cuidado, hablamos ahorita de las desveladas, el alcohol, de los medicamentos, que no se puede tomar un medicamento nada mas por tomarlo, si no se ha prescrito, nuestro médico nos cuida...y la vacuna contra el resfrío, la vacuna para la hepatitis, tuberculosis...claro que sí, yo creo que si no fueran todos esos cuidados en cualquier momento podría uno, tener algo, yo por ejemplo, sigo teniendo las mismas CD4 que hace 15 años, entonces estar indetectable por 15 años y con las mismas defensas siento que transcurrieron 15
años con medicamentos y con cuidados como de un día para otro, entonces ese es mi positivismo, que pueden pasar cinco o diez años más...

[Yes, according to the doctor’s recommendation, I have to be more careful about how many hours I need to sleep, about my alcohol consumption, as well as with the medications, because you cannot take a medication just for the sake of taking it, if you do not get it prescribed. Our doctor takes good care of us…oh and the vaccine against the flu, and the one against hepatitis, and the one against tuberculosis… and if it wasn’t for all this care I am sure that I would get something, for example I have maintained my CD4 count at the same level for 15 years, so I have been undetectable for 15 years and with the same level of defenses thanks to the medication and with the daily care I have. So that is my positive thinking to keep my health for five or ten years more.]

The next quote is from a participant that feels more vulnerable primarily due to getting health conditions that he never had gotten before:

Sí, si me siento más vulnerable, no sé si esté, pero se me hace que sí porque a mí nunca me había dado bronquitis, nunca, y ya me dio bronquitis hace poquito hace como, apenas hace como dos semanas que salí o sea, y no del todo, ahí ando pero de todas maneras si me siento más vulnerable, y, y por esa razón. Y sí, de todos modos aunque no me hubiera dado, creo yo que teniendo uno el virus pues, pues debe de considerar eso, que ya no es lo mismo o sea, esta mas, no sabe uno en ese momento, porque aparte los, los estos seguimientos son cada tres meses.

[Yes, I do feel more vulnerable, yeah, I have never had bronchitis, never, and I just got it like about, just about … I started feeling better about two weeks ago but I am still not well so I do feel more vulnerable because of that. And if I have not gotten it, because I
am carrying the virus, I should consider that is not the same, and you don’t know at the
time until you get the follow-up test results.]

4.2.2.2 ARV Treatment Beliefs

The following set of quotes will describe the participant’s beliefs of how the ARV
treatment has affected their health and sexual life. The following quote describes the
participant’s beliefs about why some people living with HIV/AIDS don’t use protection when
they engage in sexual encounters, why they do not disclose their HIV-positive status to their
partners, and how they perceive themselves as non-transmissible:

I don't know exactly, maybe for you and I it is not possible, but who are we to determine
that that person really doesn't love that other person, we are no one to say, I mean for us
that's not love but we don't live inside their mind to actually think, that is why I say
technically...[but it's not a one night stand, so they know what they doing]...No, it's a
relationship and I am telling you for more than six months and they are taking meds and I
even ask them "do they know about your...No. Have they notice you take meds...No"..."So
how do you do it"..."Well I just hide myself or I go really quick to the kitchen"...but...I
really don't understand... [And they know they are deliberately infecting their
partners]...No, they don't think so because what happens it's, I believe because I haven't
seen their medical records but since based on what they tell is they're undetectable and
they think they can't transmit. [What you are telling us here it's really important
because what would come out of this interview is your experience of people not
disclosing not necessarily deliberately to infect someone but because they
believe...mistakenly that they cannot transmit it]...Exactly I don't think...that's why I
am telling you...and I want to stress this out. I don't think they're mean people in the sense that they deliberately want to infect somebody and all this hate against humans, No! I can't say if they are in love or not but I know, I can tell that these people are not mean they don't want to do this but they're probably misinformed or... [Do you think its denial]...Probably it's denial [because if they insist in condom use they might have to disclosed, what you think?]...I don't know... [So many possibilities]...yes, there are so many factors... [If you were going to have a sexual relationship with someone how would you feel about condom use?]...Oh that's a must definitely but for me it’s not only about the condom that is why I choose not to have a boyfriend...because for me being in a relationship it's about being honest, always... so I wouldn't been able to hide my HIV status, just because we use condoms it doesn't mean I am completely honest, that's why I rather not to have relationships...at least not relationships that would entitle me or to force me to open myself.

The following quote is from a participant who mentioned to the researcher that the treatments have been getting better over the years because his previous medication regimes were giving him several health problems:

Anteriormente, en el pasado, estoy hablando de unos años atrás hubo medicamento súper agresivos que así como tomabas el medicamento tenías que tomar un Lomotil, un Imodium, para parar las diarreas intensas que te ocasionaban hasta que el cuerpo las asimilaba o se acostumbraba a ellas, pero de todas maneras, junto con, no podías tomar un alimento X a base de soya porque era chorros los que se te venían. A raíz de que tenías la flora intestinal muy delicada. Eran agresivos, te curan una cosa, actualmente no es mi caso, pero te hunden en otra.
In the past, and I am talking about a few years back, there was a medication super aggressive to the body. When you took that medication you needed to take Lomotil or Imodium to control the intense diarrhea that it caused until your body assimilated or got used to the medication. You could not consume a soy-based product because you would just have constant diarrhea. I had a very sensitive digestive flora thanks to that (medication). They were very aggressive to the body; they will heal you from a thing… It is not my case now… but they will mess up something else.]

Another participant reported that he believes that ARV medications helps the body to control HIV replication, but also affects and modifies your body shape and internal organs:

Disminuye más la bacteria o viene siendo con tres días que se los deje de tomar la bacteria va ganando límite o la bacteria se va duplicando, se va duplicando, se va duplicando, se va duplicando hasta llegar a un tope. Lo que tiene es que el medicamento mantiene la bacteria a cierto nivel, que no se sobrepase de las líneas y se mantenga en un nivel estable. Que viene siendo que no le dicen a uno (doctores) que consecuencias va a tener para que pueda hacer uno para cuidarse más. Ya ahorita ya se, que le crece a uno la joroba, le adelgazan las piernas, le da diarrea, cansancio que es lo que más me da a mí, o viene siendo le quita a uno pero le daña a otro hígado, pulmones, si me explico?

[The treatment) decreases the bacteria but if you stop taking it even for three days the bacteria spreads and multiply faster, it multiplies, and multiplies, and multiplies until it reaches its limit. What the medication does is to keep the bacteria at certain level, so that it doesn’t pass a specific stable limit. But they (doctors) don’t tell you about all the consequences that you will have, that could help you take better care of yourself. Now I
know them, you get a back hump, legs become thinner, and you get diarrhea and fatigue, which is what I get the most. Also, it affects the liver and lung, am I making a point?

4.2.2.3 Barriers to Healthcare

Many participants reported that they believed that people living in the El Paso region do not seek out healthcare services primarily due to denial, the cost of the medication, the fear of disclosing their HIV/AIDS status and confidentiality of records, migratory status, and education. Different participants mentioned the belief that language affected how PLWHA seek for healthcare in the region, but other participants believed that language was not a primary issue in the El Paso area. The following set of quotes will explain the findings described above:

The following statements describe a participant who believes that PLWHA in the region do not seek healthcare services because they enter a phase of denial, and taking the ARV medications will be accepting their illness as real:

And it’s also like a sign of denial. Sometimes being in denial is good, only if you think about it in a short term, but it’s bad in a long term because you’re just getting worse and worse and worse. But it’s good in the short, in the short distance because uh, “Ah, maybe that’s a typo on the paper, maybe that’s not me, my name right there. Maybe that’s a mistake.”

Another participant describes that he believes denial is one of the primary reasons for PLWHA in the region to not seek healthcare. He uses his own personal experience as an example:

Well because when I first got diagnosed I didn’t um, I didn’t believe I was positive. I guess I was in denial. So, I was told I was HIV positive, …took all this time for it to sink
in, and even after it sunk in I sort of just put it on the back burner like, I suppose because I wasn’t sick right, so I thought maybe the test was wrong, maybe I’m not positive, they just think I am, or... so yeah. I mean I guess the number one reason or the number one answer would be that I was in denial that I was actually infected with HIV.

The following quote describes how participants believed that the cost of the medication was a primary barrier for PLWHA to seek for healthcare services but also that lack of education about healthcare services available affects the situation:

I think that’s lack of education because yes medications are expensive, that’s something that most people know, but there’s help to pay for medications and I think that’s something a lot of people don’t know. And I’ve learned that through my work because a lot of times one of the things that comes up is that exactly, is the medication. Um, people, one of their first reactions is they’re worried about, “Well how am I gonna pay for this, how am I gonna pay for my medication? Medication is expensive, right?” And yes it is expensive but there is help to pay, there is help available to help you pay for medication. And so that is a factor because again, people know that it’s expensive, but not everybody knows that there is help for you to pay for it.

Another participant reported that medication cost is an important issue for PLWHA. Primarily those who are working or have benefits can have problems with paying for the medications because they are not eligible for State help:

Uh, now that I’ve been on Medicare, yes. Before when I used to get them through the state, they were obviously covered. Now that I’ve been put on Medicare, they take a hundred dollars out of my disability check for the Medicare itself and there are two medications that are not covered by Medicare. So every month I’m basically spending
two hundred dollars. **So the cost of the other two medications is a hundred bucks?** Uh, one is fifty dollars, and the other one is like twenty and there are co-pays that are like two or four dollars for the rest of them. So obviously I pay for them, but that takes away from maybe going out to eat or you know, treating myself to something like that. It’s definitely, that two hundred dollars is a big chunk that has been taken out of… **So do you think that’s a main reason why people do not seek healthcare?** Um, I think that would probably be a lot of it… because if they don’t know where to get it, or (pauses) I guess since I am on disability I know that it’ll be partially covered. But people that maybe are currently working and aren’t seen as being indigent, as you know, having any income or anything I think that would be a major thing for them. I they’re not having insurance, or having to pay more for insurance or more for the medications, definitely.

Disclosure was another factor that was brought up by most of the participants as a factor that may affect the healthcare seeking behaviors of PLWHA in the area:

Oh yeah! They are very scared to, as a matter of fact a lot of people will park their cars somewhere else and they walk. Because some people know that this is a treatment center for HIV so they don’t want to be seen coming or getting out of here.

Another participant believed that disclosure plays an important factor in healthcare seeking behaviors but once they have sought information and care, confidentiality stops being a primary worry:

Sí, alomejor si tienen miedo que la gente te identifique ¿verdad? como una persona enferma, pero pues ya una vez adentro (en el sistema) te explican que tu eres una, eres como un número ¿no? ni siquiera tu nombre tienes que, tienes que tener, eres un número
y se acabo o sea a nadie le interesa si, digo dentro de los prestadores de servicios ¿no?, el nombre es lo de menos, el chiste es la atención, el cuidado que te van a prestar y todo.

[Yes, I think people fear to be identified right? As a sick individual, but once you are in (the system) they explain to you that you are like a number, you don’t even have your name. It is just a number and that’s it, nobody cares about it. I mean with the healthcare providers, the name is the least important thing, what matters is the service, and the care they are providing you.]

Most of the participants agreed that the person’s migratory status is a factor that prevents PLWHA from seeking healthcare. The following quotes give a description of this factor:

Well, …if a person is undocumented I mean, where literally they have no way of crossing the border into the United States, then they have I think more trouble seeking help with their HIV than someone who is documented and can easily come to the United States for treatment.

Another participant believed that being undocumented dramatically affects the healthcare of individuals in the United States:

O viene siendo nosotros como residentes o ciudadanos deberíamos de dar gracias porque de perdida Estados Unidos si nos apoya en esto. Pero los de México o ciudad Juárez batallan mucho para esto. Y México también debería de dar la oportunidad de sus medicinas. Por eso es que estaba hablando de la discriminación. Y yo de México no tengo nada que decirle, parte de mi vida fue muy feliz allá. Y ahorita lo que está pasando en ciudad Juárez me da lástima. No lastima, me siento triste porque ese Juárez no era así.

[We as residents or citizens, must be thankful because at least the U.S. government gives us support. But people from Mexico and Juarez struggle a lot to receive care. Mexico
should give the medications too. There is a lot of discrimination. I don’t have anything bad to say about Mexico because when I lived there I was very happy but I feel pity about the situation that people in Juarez are going through. Not pity, I feel sad because Juarez was not like that before.]

Language was a factor that many participants agreed and disagreed on. It was the only factor that received almost the same number of reactions on both sides. The following quotes show one participant believing that language is a primary factor affecting health-seeking behaviors, and another quote of a participant who believes that in the region, language doesn’t play an important role in seeking for healthcare services:

For someone who’s not bilingual? Yeah its harder because I experienced here when because when I had to go into the Dr.’s office sometimes because there was this lady that she didn’t speak any words in Spanish so I have to go there sometimes just to translate for the patients, so yeah it becomes like a handicap cause you need somebody there to try to talk for you. [So do you think that people who don’t speak English…. they feel more uncomfortable to seek care?] Yes, they are embarrassed because they don’t know how to speak English and they don’t know how to speak Spanish, so.

Another participant mentioned that he believed that language doesn’t affect their access to healthcare:

Yo pienso que el idioma no es ninguna barrera, se hablan aquí (El Paso) los dos idiomas tan, tan normal como si nada, o sea, yo no creo que eso sea, si vienes aquí (la clinica) y hablas inglés pues te hablan en inglés, si hablas español te hablan en español, o sea, no, no hay ningún problema.
[I don’t think language is a barrier, here (in El Paso) people speak both languages as a very normal thing, so I don’t believe that is a barrier. If you come here (the clinic) and speak English they will answer you in English, but if you speak Spanish to them they will also speak Spanish to you so I don’t see any problem.]

4.2.2.4 Beliefs about HIV/AIDS Education in the Region

The interviewer asked the participants if they believed that the local border population was receiving enough information and education about HIV/AIDS and all of them agreed that there was a lack of education and preparation in the community regarding HV/AIDS and PLWHA. The following quotes represent the different beliefs the participants had regarding HIV/AIDS education in the region. The first one refers specifically to the belief that the gay population in region does not want to get tested for HIV/AIDS because they ignore the process and they prefer not to know their status due to the fear of receiving a positive result:

Porque ahorita de los que yo se que están en tratamiento es porque ya lo supieron, que si no quieren (el tratamiento), bueno es por ignorancia, pero el tan solo no querer saber que están infectados, creo que es ahorita un problema muy grande, sobre todo en Juarez, porque muchos no quieren ni hacerse el examen, prefieren estar en "ah, si me voy a morir prefiero no saberlo", y ese es el problema que puede haber que, estando en la ignorancia esto va a seguir creciendo. ¿Crees que se nieguen ellos mismos?, se niegan a ellos mismos y dicen "si lo estoy, no quiero saberlo", pero yo he hablado con muchos de ellos y les digo "como puedes tu decir esto si estas afectando a terceros", ¿Y porqué crees que no quieran saberlo?, es el miedo.
[Right now the people who are in treatment are there because they already know their status and if they don’t want to take it (treatment) it’s due to ignorance. But the fact of not wanting to know if they are infected is a big issue, especially in Juarez because a lot of them prefer not take the test. They prefer to think, “If I am going to die anyway, I prefer not to know.” That is the problem; by living in ignorance this issue is only going to grow more. Do you think they are in denial? They live in denial; they say, “If I have it, I don’t want to know it.” I have been talking to a lot of them and telling them: “How can you say such thing when you are affecting others” And why do you think they don’t want to know? Because of fear.]

The following quote is from a participant who states that the population in the Juarez/El Paso area does not receive enough education about HIV/AIDS regardless of their sexual orientation. He mentions that many heterosexual men and women are being affected by HIV/AIDS in the region and there is not enough prevention or information overall that is properly addressing the needs of the border population:

But it's not only gay, I think that even the straight ...heterosexual community...many maquila workers and ladies and guys...they’re also infected and affected so it's people who work ten hours a day, they don't read, they just want to go home and sleep and they might see the TV, everybody watches TV at some point so that's why I was like why not having HIV or AIDS commercial in primetime or news time, they do a lot of research and fundraise to find the cure but there is some other important side that it's education and preventing [and if you are living in other parts of the country like San Francisco or New York you would see those ads and that's why I think is important to look at the border and people that live here and the obstacles], but you know, I am lucky and
blessed to travel a lot and I have seen San Francisco, billboards everywhere in New York, Chicago, but if you go to Dallas or Houston, Nashville, Denver...uhmm..Phoenix...is not as much as San Francisco, New York or Miami, you are talking of these big cities because they are the "Mecca" of the gay community probably but I haven't seen in commercial and ads as much as in those cities that you mentioned, so it's definitely a Latino... it's...there's a lack of this in the Latino community but also in the general community in smaller cities, not necessarily big cities like those important ones.

Another participant reported that he believes that there is information available about HIV/AIDS, but unfortunately the ways of distributing the information or access to those material and information is not adequate. You would require access to a computer and Internet, as well as access to knowledgeable doctors who can provide care or refer their patients to those services:

Definitely. And that’s kind of why I you know, wanted to help to contribute to this to hopefully help somebody else. ‘Cause I know the journey for these past three years has been long and tough so, I’ve done as much as I can from finding out from my doctor, or the Internet. But somebody that may not have access to the internet or may not have access to a good doctor like the one I have, definitely that would be an issue for them. And maybe just not being aware of where to get the information, definitely. Because like I said the gay community here is not as it is in Florida, or I would think like in San Francisco where there are larger gay populations. Um, because there are a lot of gay people here, but like I said there’s that… that pre-conceived notion that it’s not a masculine thing or it’s definitely gay, or you know afraid of somebody lashing out at them for that, definitely.
Another participant also reported that not only does the general population lack of knowledge and access to information but that many healthcare providers do not know much about HIV/AIDS. This participant mentioned that his former healthcare provider was not providing the correct information to him. This quote also links the lack of education with the stigma that affects this group of LMSMLHAS living on the El Paso/Juarez area:

Nada, muchas personas ni siquiera saben para que son los medicamentos ni que existen medicamentos, fíjate a mi me toco ir a Juarez a una clínica y una doctora me dijo que tenía que lavar mi ropa aparte, que tenía que ir a un baño, mi comida aparte, todo, si me entiendes...cuando yo conocí un poco mas de esto dije que estúpida la verdad [Y medico], lo que siendo un médico me dijo eso me quede así (expresión facial) y ahora que yo tengo más información y que se de esto, me falta conocer mucho más todavía porque yo tengo 46 años cumplidos y bien vividos, me falta mucho que conocer pero me quede con la boca abierta gacho cuando ella me dijo eso que yo tenía que hacer todo aparte, mi baño aparte, lavar aparte y...que le pasa yo hasta ahora no llevo una vida normal y todo lo hablo con mis hermanas abiertamente así como si platicara contigo y no pasa nada.

[Nothing… a lot of people don’t even know what the medications are for, or even that there is treatment available. I have to experience going to a clinic in Juarez, and one doctor told me that I had to wash my clothes separately, That I had to use only one restroom and that I had to have my food and everything else all separated. When I learned a little bit more about it I thought that she was stupid. And she was a physician. Yeah, I could not believe it. Now that I have more information and I know that I still need to learn more. I have 46 years well-lived but I was left with my mouth wide-open]
when that doctor told me all that about eating and showering separately… What is wrong with her? So far I have a normal life, I speak openly with my sisters about everything as I am talking to you now and nothing bad has happened]

4.2.2.5 Stigma

The role of stigma among this population is another important health belief that affects how HIV-infected Latinos in the region experience healthcare. Almost all participants reported being affected by stigma in different areas of their life, such as relationships, social support, and treatment services. The following sets of quotes describe the participants’ experience with stigma on different levels of their lives. The first quote is from a participant who reported that stigma affects the way HIV/AIDS prevention outreach is planned. He also mentioned that all the HIV/AIDS research and information targets only elite groups and the rest of the population does not receive any information about or receive benefit from research that will be available years later:

I don't understand why would you see billboards about breast cancer or Alzheimer disease or TV adds about the breast cancer foundation and yes, you hear about HIV and AIDS, and the red ribbon but it's more… I personally think is more social and elite, you see this thing is on the artist and raising funds for investigation but what about education, there is lot of money raise for investigation, they want to find a cure but they forget about the present...they want to look for a cure how many people are getting infected everyday and a lot of the money go just for that, but that's not solving the problem not finding the cure it's in informing, so why is there no billboards on the freeway about the 20 minute test or TV commercials on primetime.
The next piece of information is from a participant who felt discriminated many times when he went to seek healthcare in the Mexico border:

México está muy fuerte lo que es la discriminación...[claro]... también los médicos tienen...en cierta parte los médicos te protegen a ti como enfermo, porque desde ese momento que el doctor se dio cuenta de mis resultados...este...en un principio si me hicieron sentir como que...te hacen sentir como el único responsable de esto..."tú debes estar consciente de que hiciste mal", entonces creo que...estamos en... la ciencia está muy avanzada quiero decir y creo que no se deben de tratar a las personas así. No tengo ningún rencor con los doctores, ni mucho menos...al contrario, estoy muy agradecido con los doctores...

[In Mexico, there is a lot of discrimination, even physicians do it… Physicians should care about you as a sick person, but from the moment the doctor knew my results… like…at the beginning he made me feel like…he made me feel that the one to blame. He said, “You should be conscious that you did wrong,” So I think that…science is very advanced, I mean people should not be treated like that. I don’t have any resentment towards doctors, not at all; on the contrary, I am very grateful to them…]

The following quote is from a participant who was forced to quit his job because his employer found out about his HIV positive status, so much so that he received a demotion; he decided to quit and re-apply the following year and did not receive the job:

Mi cambio de puesto, eso también influyó mucho...y en su momento lo comente, tomaron la decisión y me hicieron ver que como que fue algo que yo tome, yo no quería irme, [en cierta forma te hicieron renunciar], sí, yo le decía "y todo lo que yo te he dado a ti como institución, el ahorro que te he dado", que no fueron cinco dólares, fueron miles de
dólares al año que le di a ahorrar a la empresa. Si dejé las puertas abiertas, volví a pedir trabajo el año pasado en la misma empresa, hasta ahorita no me han hablado ni me hablaran, debido a la discriminación tan fuerte que hay.

[The demotion I received at work influenced my decision about quitting quite a bit… by the time I tried to bring it up, they had already made the decision. They made it seem that it was something I decided to do, I did not want to leave (So in a way they made you resigned?) Yes, I told them “…and what about everything that I have given you as a part of the institution? All the money I have saved you?” Which was thousands of dollars. We ended on good terms, last year I asked the same company for a job and have yet to be contacted back. I don't deserve the amount of discrimination I am experiencing.]

A participant mentioned that he lost his relationship of three years when he was diagnosed as HIV positive. He states that from the moment he told his partner, his partner was cold and did he not feel any support or understanding from him:

Tres años juntos y nos volviamos a separar. Cuando yo me entero que estoy infectado…el empezó…I felt his rejection immediately, he said that he supported me; however I noticed that he didn’t want to be with me sexually or emotionally. He practically left me on my own, at which point, I decided to break things off with him and stop committing my time to him if he could not understand.]
4.2.3 Health Practices

This section is focused in describing the different health practices that participants implemented on their daily activities to maintain good health as well as the ones used to complement their ARV medication and to treat or prevent opportunistic infections. Participants reported different health practices, which were classified in the following subcategories: Frequent Health Practices, Sexual Health Practices, Cross-border Healthcare, and CAM practices.

4.2.3.1 Frequent Health Practices

This section is focused in health practices that participants reported using frequently to maintain good health. The quotes under this section are from participants who reported incorporating different behaviors such as diet and physical activity on their daily life since they were diagnosed with HIV/AIDS. The first set of quotes describe the changes in diet that different participants mentioned to the research, this changes in diet were driven primarily to increase their overall health, as well as to counteract the side effects that the participants’ treatment regime were having in their cholesterol levels and fat distribution.

The following quotes describe how participants reported incorporating different healthy foods that they did not eat before their HIV/AIDS diagnosis, increasing the amount of greens and other healthier natural foods, and substituting existing foods products in their diet for healthier options of the same product:

I definitely watch what I eat now, and try to eat more healthy. Um, don’t really go out to eat much like I said maybe once or twice a month with family, if that. Basically I eat a lot
of fruits and vegetables and I try to eat a lot of fish and chicken. So that’s mainly what I eat. Well, well being Mexican I mean you know everything’s fried or, it has queso on it or this or that so, every now and then I indulge myself, I do love it so I’m not gonna lie. But I definitely try to watch more what I’m eating.

Another participant reported incorporating healthier substitutions for foods that were common in his day-to-day diet:

Simplemente si cambie…como te podria poner el ejemplo, si el pan de caja, el pan rebanado, comia pan blanco, bueno era blanco ahora lo cambie al integral no?. La tortilla de harina en vez de que sea tortilla de harina normal blanca, ahora es integral. Las carnes, ya no como tanta carne roja, como carne más blanca. Trato de comer un poco mas fruta, más verdura. Este, la leche pues que sea de la mejor, deslactosada, de mejor digestion, 2%, o sea algo mas ligero.

[I simply change foods…how can I explain it to you, like the regular white sliced bread, I used to eat it but now I changed it for wheat sliced bread. Flour tortilla instead of the regular type (white); now I use wheat flour tortillas. I eat less red meat and more white meat instead. I try to eat more fruits and vegetables, and the milk I try to get the best and lactose free for better digestion and 2% to get something lighter.]

The following quote is from a participant who reported that he did not like greens and fruits but has now incorporated them into his diet in large amounts:

Como demasiada verdura, para mí se me hace imposible pero si trato [no te gustaban las verduras] no crudas si me las, más que cocidas o en pollo no me gustaban, pero si me las, como hervidas no…[crudas] sí. Si en las verduras, antes las verduras no las comía
muy seguido, no me gustaba ni la fruta pero ahora sí aunque no me gustan me echo mi manzanita en la bolsa o equis, o de repente así me hago mis ensaladitas.

[I eat a lot of vegetables. For me it was an impossible thing to do but I try. [You did not like vegetables?]… I ate them raw but if they were cooked or with chicken I did not like them, I do eat them but not cooked… [Raw] Yes. I did eat vegetables very often, I did not even liked fruits but now I do eat them, even if I do not like them I pick an apple and put it on my lunch bag, or sometimes I prepare my salads.]

The following set quotes are from participants who primarily changed their diet by taking out different types of foods from their daily diet that are rich in fat, carbohydrates, or that were too irritating to the stomach:

Desde un principio porque seguí una dieta clásica mexicana, pero luego que ya tuve los cambios…de…lipodistrofia… a comer todo a la parrilla, lo que es más vegetales más fruta.

[From the beginning I followed a classic Mexican diet but when I had the changes…the…lipodystrophy… I eat everything grilled, and more vegetables and fruit.]

-Ya no tomo casi leche, y luego carne roja, bueno no la he quitado la he disminuido bastante casi al, casi al 100% más bien como por necesidad esas; si porque a veces come uno por necesidad, sale o trae mucha hambre y ya no hay otra cosa pues comes verdad, pero si es opcional la quito.

[I rarely drink milk or eat red meat anymore, well I have decreased the intake almost 100% but sometimes I eat it due to necessity when I go out and I am very hungry and there is no other thing to eat, but if I have options I do not eat them.]
- Pues he tenido que cambiarla muy a mi pesar porque hay cosas muy irritantes que me encantaban pero por mi problema de las úlceras y eso tuve que cambiarla. Ya procuro no comer picantes, ni tanto, tanta grasa.

[- I have to change it (the diet) much to my dismay because there are things that I used to eat that now irritate my stomach due to my ulcer problem, that is what I have changed. I try to avoid foods that are high on fat or spicy.]

The following quotes are from participants that incorporated physical activity into their daily life and practices. Some participants incorporated activities that are considered moderated physical activities such as walking, and others incorporated vigorous physical activities such as weightlifting and cardio machines at the gym. The first quote is from a participant that has incorporated walking to his daily routine to improve his health:

Vivo en un fraccionamiento privado que tiene un parque en medio y camino. Y cuando no tengo ganas de caminar porque esta frio o esta caluroso, tengo una caminadora que está en la cochera que es más o menos de este tamaño, grande y una bicicleta...eh...como se dice.... [Estacionaria], si estacionaria y ahí camino un rato o bicicleteo.

[I live in a subdivision complex that has a park in the middle, I walk there. When I do not feel like walking because it is cold I use a treadmill that I have in my garage, it is more or less this size (moving hands to show size). I also have a bike… Or how is it called?

**Spinning bike?** Yes a spinning bike. So I walk there for a while or do some spinning (in the garage).]

The following quote is from a participant that incorporated weightlifting in his daily practices:
Do you exercise? Some…about three times a week [what do you do?] just a little workout I have a 10 pound-weight I do sit ups and pushups… [Do you do it at your home?] Yes.

The following participant reported having positive health outcomes by incorporating a gym routine:

Andaba todo volado porque los muchachos de la clínica me decían que ya estaba muy cambiado, ya tenían un mes que no me veían, entonces siento que si se están viendo resultados, lo bueno es que me he topado con dos entrenadores que me han ayudado mucho y no me cobran lo que no me tienen que cobrar, de hecho a uno no le pague como por seis meses y ahora ya le dije "sabes que, te voy a pagar", que es una cantidad ridícula para él, pero como él y yo…bueno el sabía que yo tenía HIV y como que mostraban más interés en mi y veían como un reto que una persona con HIV también puede desarrollarse…no es que me quiera poner como un mister universo, pero también pues estar ejercitándose, estar a dieta y estar motivando a otras personas es como saber que cualquier enfermo puede tener beneficios y te regañan cuando no sigues la dieta.

[I was all happy because the clinic staff told me that I was very changed. They haven’t seen me for a month, so I believe they have been seeing the results (of gym training). I met a couple of trainers that do not charge me what they are supposed to charge, in fact, I haven’t paid one of them for about six months but I told him “You know I will pay you,” which it is a ridiculous amount for him but he… well he knows I am HIV positive so he sees me as his challenge. He wants to show that someone living with HIV can also train and get fit… is not that he wants me to be Mr. Universe but he knows that any person]
struggling with a health condition can have good health benefits by working out and having a healthy diet.]

4.2.3.2 Sexual Health Practices

The following section reports the health practices that participants used to improve their sexual health. The most significant reported practices were condom use and a decrease in sexual encounters. The next quote is from a participant who reported using condoms in every sexual encounter he has:

Sí, siempre. Ya hasta hay de sabores y todo eso (risas)...yo sé que no es lo mismo, pero hay muchos condones que ya son muy delgaditos.

[Yes, always (use condom). Now they even sell flavored ones (laughs)… I know that it does not feel the same, but now there are many condoms available that are very thin.]

The next quote is from a participant who reported using condoms in every sexual encounter with the exception of oral sex. Even though the participant reported using condoms to perform oral sex, he admitted that there are times that he does not use condoms during this act:

Como un hábito, ¿Siempre lo has utilizado? Si, aunque a veces se me pasa con el sexo oral (hacia alguien mas), y ahí es cuando entra mi miedo, y le platico a la doctora y después me regaña… Es una tontería de mi parte porque se los riesgos que corro y de todas maneras no le hago caso a mis doctores, entonces también estoy jugando mi salud.

[It is a habit. (Do you always use them [condoms]?) Yes, but sometimes I do not use it with oral sex (performing to others), and then is when I get scared. When I tell my doctor she get upset with me… I know it is foolish of me not to use it because of the risks that I get into (co-infection), but sometimes I still do it. I am gambling with my health.
The following quote is from a participant who reported using condoms in during sex very often. He mentioned to the researcher that before his diagnosis he rarely considered the use of condoms during sex:

I try to, yes (use condoms). I’m not gonna say 100% that I do always, but I…before my diagnosis I never even considered it. It wasn’t really something I would think about. It’s like if I used a condom, fine, if I didn’t, fine, before my diagnosis. Now, I uh …try to insist more that there is a condom used. So yeah, that has changed.

The next set of quotes are from some of the participants who reported decreasing their sexual activity as a way to prevent any co-infections and to prevent the risk to infect other with HIV/AIDS. The first quote is from a participant that reported decreasing sex encounters due to the fear of infection someone with HIV:

Claro que si demasiado…simplemente tengo miedo de infectar a alguien, tengo miedo de ver a alguien persona sufrir como sufri yo es lo que simplemente por eso simplemente digo yo y me da miedo tener una relación.

[Of course (decrease sexual encounters), dramatically… I am simply afraid to infect someone, I am afraid to see someone suffering as I did. And only because of that I am afraid to start a relationship with someone.]

The next quote is from a participant who mentioned decreasing his sexual activity but still trying to keep it balanced and enjoys it in a safe way:

Pues si tiene que disminuir, tiene que haber toda la seguridad y no nomas porque tengo ganas, también hay que ver con quien, como, cuando...tampoco puedo decir he llegado a la abstinencia, me considero seguir siendo normal dentro de los parámetros que debe de haber...
[Well yes, it has to decrease, and you have to have all the protection and not go and do it (sex) just because I want to. You also have to be careful with whom do you do it... I cannot say that I have reach abstinence, I believe that I a still under the normal parameters...]

A participant mentioned to the researcher that he lost his relationship because his partner did not want to have protected sex:

Pues si porque, porque antes del diagnostico yo no me protegía tanto, me protegía pero no tanto ¿si sabe cómo? y ahora sí, por ejemplo el, el, yo digo que el motivo de que no seguimos mi pareja y yo, con el que tenía diecisésis años, pues fue ese, porque yo quería protegerme y el no ¿si sabe cómo? entonces hubo problemas, que porque no se siente igual, que… Si el no, el “no, y que mira que no pasa nada. No y que así” y hay muchas cosas que “¡que no!, que la sacas antes” ¿si sabe cómo? y así, no, no, pues yo sabía que, yo sé el riesgo y el también porque el también asistía conmigo a los seminarios y toda la información que… aparte de ese otro, es otra cosa, que al principio cuando, cuando salí infectado pues estaba, hay mucha información, no sabe uno, no sabe uno pues ni cuidarse bien, ni, tanto como en alimentación como en, en precaución de, de re infectarse o de infectar a otros, y pues pero con los seminarios pues va uno aprendiendo mucho

¿Entonces, este, le atribuye a la protección el hecho de que se, perdió la relación pasada? Sí porque es diferente, sí, sí, porque él quería que sin condón a veces, que el sexo oral que no me pusiera condón que porque sabía muy feo y que… ¿si sabe cómo? cosas, es eso las cosas que, que… y hasta cierto punto pues tiene razón, es cierto, o sea, no es lo mismo, no es lo mismo, ni la penetración si con condón que sin condón para uno tampoco, o sea no se siente igual ¿sabe cómo? pero se siente muy feo estar infectado.
[Well yes, because before my diagnosis I did not protect myself that often, I used protection but not very often you know, but now I do. For example, I believe that the reason that my partner and I are not together anymore after a 16-year relationship, was that I wanted to use protection and he didn’t. Then, there were lots of arguments because he said that it doesn’t feel the same, he used to tell me that nothing was going to happen, that I could pull it out before…you know how? But I know the risks and he knows them as well because he used to go with me to the information seminars… when you get diagnosed, you don’t know how to take care of yourself so the seminars helped a lot. **So you attribute the use of protection as the reason why you lost your last relationship?** Yes, because he did not want to use protection sometimes, he did not want me to wear a condom for oral sex because he said that it tasted bad… to a certain point he is right, it doesn’t feel the same with a condom but it feels worse to become infected.]

4.2.3.3 Limited Substance Use

Most of the participants in this dissertation study reported reducing their substance use, primarily alcohol and tobacco. Even though all participants in the study reported to use elicit drugs in their lifetime such as cocaine and methamphetamines, they stopped using them long time before they were diagnosed with HIV/AIDS. The following quote is from a participant who reported decreasing his alcohol consumption:

Trato de no tomar tanto por lo de la depresión, si tomo bastante al siguiente día siento los efectos que me hace sentirme mas…por eso trato de no tomar, si acaso unas seis cervezas y ya es mucho. [¿más o menos, **si habláramos por semana con qué frecuencia consumes alcohol a la semana?**], Bueno, digamos que en un mes salgo como dos veces,
que sería en esas dos veces me tomaría unas tres, cuatro cervezas, [¿por las dos o en cada ocasión?], En cada ocasión.

[I try not to drink too much alcohol because of my depression. If I drink a lot, the next day I feel the effects that make me feel more (depress)... That is why I try to not drink, and if I do, it is about six beers, and that is too much to say. (On a weekly basis, how much alcohol do you drink?) In a month, I usually go out a couple of times, which I would probably drink three or four beers (on both nights?) On each night.]

Another participant reported cutting out cigarettes because he wanted to be healthier and after a few attempts he was able to quit smoking:

Anteriormente fumaba dos o tres cigarros al día y una semana estuve que me daba casi a diario y dos o tres veces, dije "bueno que fregados tenga la necesidad de estar fumando", y ya de ahí hace como ocho meses lo deje y no he vuelto a agarrar el cigarro para nada. [I used to smoke about two or three cigarettes per day but I remember that one time I was smoking two to three cigarettes and I said to myself “No one is forcing me to smoke, why do I need to keep doing this to myself” and since then I quit smoking. There has been eight month since I quit.]

The next quote is from a participant who reported quitting alcohol when he found he was HIV positive:

Antes del virus era muy borrachito, me gustaba mucho la cerveza, me encantaba andar con mis Tecates para arriba y para abajo. Eso sí, tomaba mucho, los fines de semana, a veces entre semana una cervecita o dos, un seis como le llaman en México, pero sí, si tomaba bastantito. ¿Y después de tu diagnostico? Cero ¿Nada? Nada, que si se me ha antojado verdad, así una cervecita con clamato.
[Before the virus (HIV) I was a drunk, I loved beer, and I was drinking Tecate everywhere and more during the weekends and a couple of six-packs during the week.
(And after your diagnosis?) Zero. (Nothing?) Nothing, but I do not deny that sometimes I crave a beer with clamato.]

4.2.3.4 Cross-border Healthcare

Receiving healthcare across the border is one of the primary ways that participants in this study obtained complementary healthcare. Many participants reported going to The Mexican side of the border to received healthcare and vice-versa. The following quotes describe the participants’ experiences in seeking cross-border healthcare. The first one is from a participant that used to seek for healthcare in Mexico but he was not very happy with the quality of the service:

En México (¿En qué lugares?) Es el Seguro Popular, que es algo muy diferente a acá, allá nada mas te dicen aquí está el medicamento, tómeselo y en un mes venga, y aquí no, aquí en la clínica me han tratado muy bien, la doctora es muy linda persona, me dice: mucho ánimo, no va a pasar nada, vas a vivir, tómate tus medicamentos, abrazos, besos, lo que en México no.

[In Mexico, the Seguro Popular is very different than here (healthcare). There they only give you the medication and say to you “come in a month.” But here, the clinic staff treats me very well, the doctor is such a nice person, she always tells me: “Cheer up, it is ok, you will live” and she hugs me, which it did not happen in Mexico.]

Another participant reported receiving his ARV treatment in Mexico and receiving complementary care in the U.S.:
A mi me lo dan en México el tratamiento, yo me atiendo en los dos lados, me lo dan en México el tratamiento. Aquí prácticamente son vitaminas, pero el medicamento de lo dan en México, para el VIH, porque yo empecé en México, ahí fue todo el proceso, en México, pero unas tías me decían: vente para acá, mas atención mejor en El Paso, y no sé, como yo siempre crecí en México yo le tenía más fe a los doctores de México y ahora he visto la diferencia entre México y aquí, la clínica La Fe, he visto mucha diferencia. No estoy diciendo que no son buenos, claro que son buenos los doctores en México, pero he visto mucha diferencia aquí en Estados Unidos, que atienden un poquito mejor a la gente que tiene VIH.

[I receive my treatment (ARV) in Mexico and here I only get supplements and vitamins. My aunts keep telling me that there is better healthcare in El Paso but because I grew up in Mexico I have faith in the doctors there, but I can see a clear difference in healthcare on both sides. Doctors in Mexico are good but here (U.S.) doctors treat people living with HIV a little better.]

The following quote is from a participant who prefers to receive healthcare in the U.S. side of the border because he feels more comfortable about the privacy and secureness of information that when he used to receive healthcare in Mexico:

En México si te hablan por tu nombre.. No es porque tenga uno miedo verdad a, a la demás gente porque la demás gente está pasando lo mismo que uno verdad, sino pues es privado, es cosa privada ¿no? de lo que, de cada persona, es cosa privada; por ejemplo aquí nos llaman por número, y allá no.

[In Mexico, they call you by your name. It is not that I am afraid or so because the rest of the people there (HIV clinic in Mexico) are going through the same thing, but I believe...]

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that should be something private. For example, here they (clinic staff) calls you by a number.]

The next quote is from a participant who lives in Juarez. He reported that in a few occasions he has missed his ARV medication refills because he was not able to call the clinic to set an appointment and in order to not miss a dose he had to borrow medications from an acquaintance:

Le piden a uno que llame para ordenarlos y de allá no puedo llamar a veces y, y luego a veces que se pasa, se tarda más, he tenido que conseguir prestados medicamentos con una persona que, que toma los mismos y me ha prestado, mientras que llegan a…

[To order them (medications) you have to call. And sometimes I am not able to call and my medications get delayed. Then I have to borrow the medications from an acquaintance who is taking the same medications I do until mine arrive…]

Cross-border healthcare has also been affected by the border violence situation. Many participants reported decreasing their visits to Juarez or just going directly to purchase medication and return back to the U.S. The following quote is from a participant who does not go to Juarez as often as he used, causing him a decrease in the purchase of medications:

Yes, it has affected me. Because if I ever went to Juarez like a year ago let’s say, or even six months ago, it was just to go buy medications, and then come right back. And it wasn’t even like way deep in Juarez it was just literally right across the border. But…now I hesitate to go even just for like 20 minutes or half an hour or whatever.
4.2.3.5 Complementary and Alternative Medicine (CAM)

The use of complementary and alternative healing practices was very common among participants in this dissertation research. Many of them did not even consider them complementary healthcare (such was the case with herbal supplements) because the practice was very common within the culture of the group that became part of their daily diet or activities. The following quotes will describe the different types of practices that participants reported using most frequently. The first one is from a participant who uses herbal supplements and to treat the ARV medication side-effects:

I have been drinking this natural thing with aloe vera and nopal, its “sabila y nopal” it’s a liquid and I mix it with orange juice and drink it. And how do you feel when you drink it? I really make me feel (good)…it got rid of my acid reflux. I used to have really bad heartburn all the time. And my doctor said that it’s something in aloe vera that heals. It will heal if you are getting an ulcer. It’s that good and maybe that’s what it did because I don’t have it anymore. I got rid of it, so I keep drinking it. I just take it in a little shot glass and put it in my juice every day. So did you always use it? I’ve been using it for a year now. And did you use it for your reflux or also for other things? At first yes, but then I realize that also does a lot of other things that are good for you, it detoxifies you and our medications carry a lot of toxins. Do you know that right? So some people get toxicity syndrome from taking so much meds so this thing helps you to de-tox everyday and feel better because you don’t keep those toxins in you. You flush’em out every day.

Another participant reported using some herbal supplements without any effect on his immune system, he also reported going to the Mexican side of the border to received
complementary healthcare to increase his immune function naturally with an enzyme treatment provided by a doctor in Juarez:

I use multivitamins. Before I would not care if I would have multivitamins or not...uhmm...I used to take at the beginning of it Echinacea, but then I read about it and it's not really affecting or it has prove not to do anything for HIV, in other words it doesn't work. On other people it has worked and it's proof. But in people with HIV unfortunately Echinacea doesn't do anything...uhmm...to feel better I drink that noni juice...that Hawaiian juice...ohh! And something very good "Factor transfer" I used to take... What is it? It’s...I believe they are enzymes pulled out of the colostrum’s milk...the breast milk, those enzymes are supposed to be very, very good specially for the kids...they prevent them to get sick...and you can buy this? You can buy this, they are capsules and it has proven in fact...I knew this way before I was diagnosed when I was doing a study about, an interview for television about it...and I interview this doctor that it's one of the two doctors who do that in Juarez, and this doctor has proven that factor transfer cures a lot of diseases that all the antibiotics and all the things cannot do...

Another type of complementary practices that participants reported to use with the purpose of achieving a better state of well-being is yoga, which it was used as a way to cope with stress. The following quote describes the experience of a participant that uses yoga as a mean to achieve meditation and relaxation:

Yoga tiene muchas… ramificaciones por así decirlo, que está muy relacionado con la medicina natural, con, pues ahí hay meditación ¿si sabe cómo? hay concentración, a eso, no sé si a eso se refiera ¿Y siente algún efecto cuando practica la yoga? Sí, si ¿En qué
forma? Pues yo trato de… me ayuda, si ando muy estresado yo, creo yo que me ayuda la relajación, para relajarme.

[Yoga …has many of ramifications, is related to the natural medicine, because though it you can meditate. Do you know what I mean? There is focus. Do you feel any effect of practicing yoga? Yes, yes. What kind? Well… it helps me when I am very stressed, and it keeps me relaxed.]

Another participant reported using spirituality to obtain a better state of well-being. He mentioned that by increasing his levels of spirituality he also increased his practices and interest in meditation and yoga:

De hecho me gusta mucho leer sobre cuestiones hasta cuestiones de religión, pero no para practicarla sino para entender en la parte espiritual de uno, en mí, en entender cuál es la historia de la humanidad y a donde vamos porque ahí estoy incluido yo. El entender que si quiero crecer, tengo que empezar por entender a los demás, para entenderme a mí. Entonces eso me ha llevado a practicar yoga, me ha llevado a hacer meditación, me ha llevado a… compartir mi experiencia con las personas.

[I like to read a lot about religion, but not to practice it but to understand my spiritual side, the history of humanity, and where do we go at the end. To understand my need to grow as a person, I need first to understand the others. This has taking me to practice yoga and meditation, it has also serve me as support to share my experience to others.]
Family played an important role among the study group, followed by friends, and partners support.

### 4.2.4.1 Support from Family

Some participants mentioned receiving little support from family and friends, but the majority of the participants in this study reported having a good support system from family members. The following quote describes a participant’s experience of family support, after he disclosed his HIV positive status to them:

> Con mi familia hasta ahorita todos saben porque ya mi padre falleció, desde que mi padre falleció yo me puse la meta de empezar a platicar con cada uno de mis hermanos y hablarles con la verdad y decirles...ellos me escucharon, me entendieron, y al contrario se sienten orgullosos de mi por todo lo que pase y siempre están...ahorita llego y empiezan..."y porque te tardaste tanto, y que te dijo la doctora, como estas, seguro que no me dices mentiras, cuando quieras ven...", incluso una hermana mía ya vino conmigo, otra también ya vino aquí a la clínica, con la doctora...una de hecho le preguntó mucho a la doctora y la doctora le respondió que voy al pie de la letra.

[Everyone in my family knows (about the HIV positive status). I told them after my father passed away. When I told them, everyone listened to me and supported me. They are always checking what I need, for example when I arrive home everyone ask me how have I been feeling? What the doctor say to me? … Even one of my sisters came to this clinic with me and asks to my doctor about my health.]
The following quote is from a participant who did not had the support of his family when he first disclose his HIV status to them but now he has a very good relationship with both of his parents:

Mis padres lo tomaron que yo me sorprendí de cómo realmente mis padres me aman y no pensé que me quisieran tanto, sobre todo mi papa que es muy machista...ahora lo vez y esta cambiadísimo ahora sé que da su vida por mí porque nadie me haga daño, lo que no me dijo cuando quise escucharlo, pero nunca es tarde para escuchar que tus padres... yo sé que mi madre siempre me ha querido, pero es un poquito más por el que dirán.

[I was very surprised with my parents’ reaction. I know they love me but I did not know to what extent, specially my dad that is very machista... He has change a lot, I know he will die for me and it’s never to late to hear that your parents love you… I know my mother loves me too but se worries too much about what other people may say.] Another participant reported having support from his siblings but only to certain extend. He also mentioned that when his brothers get under the influence of alcohol they become verbally abusive to him:

Well my mom and dad are deceased. But my brothers are all sad. They say they love me and everything but when they’re drunk they say, “Ande pendejo, it’s your fault for being HIV positive, you should’ve taken care of yourself.”

4.2.4.2 Support from Friends

This section explores the participants’ support from friends. The findings in this study show that many participants lost friendships due to the disclosure of their HIV status. On the
other hand many participants decided to isolate themselves and reduce their social activities with friends to avoid disclosure of their HIV status. The following quote is from a participant who due to the border violence stopped visiting his friends in Juarez who was very close to him and represented an important source of support:

When I was first diagnosed, I could say I had a friend, who was a really supportive person for me in that specific time and he was in fact very supportive and important person to me in that time but he lives in Juarez now, we stopped going out, we stopped going to Juarez, so we had kind of like...got distant.

The following quote is from a participant who decided to isolate himself from any of his friends due to fear of disclosing his HIV status to them:

Porque las amistades que tenía antes ya no las miro y trato de no mirarlas por la cuestión de que simplemente te preguntan como estas flaco, que te has hecho oí este comentario y es mejor retirarse para no ser tan afectado.

[I try not to see friends that knew me from before (I was diagnosed) because they always ask me ‘what happened to you?’ ‘You look too thin.’ It is better to distant from friends so their comments won’t affect me.]

Another participant mentioned that he has received support from his real friends and he considers the people who have walked away acquaintances and not real friend:

No, con ninguno hasta ahorita [sigue siendo igual?], si, hasta un poquito más fuerte...todas las personas que he conocido...muy poquitos me han rechazado y los que me han rechazado no eran realmente amigos eran conocidos...y mis amigos bendito sea Dios, siempre me han apoyado.
No, it has not change (relationship with friends). *(Is it the same [friendship]?)* Yes, and it is even stronger… all the people I have met [support me]… and only a few have rejected me. And the ones who have rejected me were not real friends, they were acquaintances… and my real friends, thank God they keep supporting me.]

### 4.2.4.3 Support from Partner

Most of the participants reported being single or not seeing someone for romantic or sexual purposes, but from the participants who reported having a partner or being involved romantically or sexually with another person reported mixed experiences of support from their partners. The following quote is from a participant who starts having problems with his partner due to the participant’s HIV positive status:

> Um, we started having less sex, for one. And I think even though we didn’t verbalize it, but I think that had a lot to do with it (HIV diagnosis); the fact that he was now positive and he knew that I was and I… And so, in the long run we ended up now just, we don’t even talk now. And so yeah, it changed.

The next quote is from a participant who was expecting complete rejection by his partner after being diagnosed with HIV, but instead he was surprised of all the support he has received from him:

> Sí, mi pareja sí (apoya). [Tu pareja es positivo también?] No, [y cuál fue su reacción cuando le comentaste de tu diagnostico?], No, es como te digo yo esperaba sentirlo, yo esperaba un rechazo de parte de él, pero fue como una cubeta con agua fría…surprise…y básicamente el me ha apoyado y me seguirá apoyando. Me ayuda mucho, aparte que me ayuda económicamente, “que ándale tus vitaminas, que no comas mucha grasa”.

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[Yes, from my partner (support). (Is your partner positive too?) No. (And what was his reaction when you disclose your diagnosis to him?) I was expecting rejection from him but I received a big surprise… He basically has supported me all this time and including economically. He takes care of me and gives me my vitamins and watches my diet.]

The following quote, describes the experience of one participant reporting loosing his partner due to his HIV diagnosis:

Yo estaba en una relación de...ya era como de ocho años...de Off and On, pero siempre duramos como un año, tres años juntos y nos volvíamos a separar cuando yo me entero que estoy infectado...el empezó...yo sentí su rechazo inmediato, según el decía que me apoyaba pero a su vez no quería estar conmigo sexualmente ni emocionalmente como quien dice me dejo solo y ya fue cuando tome yo la decisión de separarme, por no comprometerlo si él no podía entender.

[I was in a relationship for about eight years… on and off…but we always lasted a year or three together between break ups. I felt his rejection since I told him I was infected… He said he was supporting me but at the same time he did not wanted to have sex with me and became emotionally distant. I was the one who ended up the relationship because I did not want him to stay with me if he was not committed.]

The next quote is from a participant who broke up with his partner from Juarez because he was afraid to cross due to the increased border violence that it was occurring at the time:

Cuando miraba a ese muchacho en Juarez me decía “Porque no quieres venir a Juarez” y pues yo le decía que por lo que está pasando, y él me decía “Pues a ti no te van a agarrar, a ti ni te pelan” y no es que no sepan quién soy yo pero no quiero ser una
4.2.4.4 Partner Violence

The majority of the participants in this study group reported being victimized by a previous or current partner. The types of abuse reported by the participants ranged from verbal, physical and sexual. The next quote is from a participant who was being abused by his partner for many years. The participant also reported fearing for his life and his pet’s:

Fue una relación poquito difícil porque en cierta forma trunque muchas cosas, me separo de muchas amistades, del modelaje...que aparte el modelaje no lo extrañaba tanto...y pues hubo una relación violenta y abusiva...y lo tolere mucho tiempo...fue una situación que no te puedo explicar porque, tal vez por miedo...[¿Fue física?], fue física, verbal...e incluso en dos ocasiones...no sé si llamarlo como violación, pudo haber sido...fue [¿Contra tu voluntad?], si fue a la fuerza, e incluso abusaba de mi mascota...tenía mucho miedo de que llegara un punto en que nos agrediéramos tanto que cualquiera de los dos fuera a perder la vida...llegar a lastimarnos a tal grado. El me provocaba mucho, siempre...
me empujaba y yo me contenía porque si lo provocaba se hacía más violencia y el siempre ha sido más fuerte que yo.

[It was a difficult relationship because I gave up many things, he separated me from friends and family, from modeling which I loved to do… *(Was there any physical abuse?)* Yes, it was physical, verbal, and even in two times…I do not know if I should call it rape… *(Was it against your will?)* Yes, he forced me…he also hit my pet… I was very afraid that the situation escalated to the point of any of us losing our lives… He was always provoking me and pushing me. I just have to hold my emotions because if I said something the level of violence increased; he was always stronger than me.]

The next statement is from a participant who realized at the time of the interview that he might have been involved in an abusive relationship. He mentioned to the researcher that one time he went to the hospital due to a fight with a partner:

Uhm, …that’s kind of hard to answer. Not because, I mean, I’ve been in a relationship where there was fighting and stuff, but I wouldn’t consider it an abusive relationship. But then now in hindsight maybe it really was and now that I think about it, I mean, there was a point before the person I was talking about the most, before that, way back when I was 19, I met a guy and we were together for a while too like, 5 or 6 years. And um, one time it actually came to the point where we had a fist fight where I mean I had to go get stitches (chuckles) from a, …from an impact that happened.

The next quote is from a participant who was involved in a violent relationship for a whole year. He mentioned calling the cops several times but they never did anything to protect him:
Oh yes, for about a whole year. I was living with some guy that as a matter of fact he already passed out from HIV but he will be that kind of people that are really, really nice but if you give him a drink he will turn into a devil, you know what I mean? Totally change and he will scare me because he used to beat me up really ugly for a whole year and it’s like a cycle, do you know what I mean that you can’t get out of, even thou you know you been hurt you are always back and you can’t break the cycle. And the thing was that I tried to get away and he goes and looked for me. He will do stuff to my parent’s house or punch their tires so I have to go back. [So did you feel threaten by him?] I did yeah back when I was with him but he is not here anymore, he passed away.

Do you think that the cops were in a certain way discriminating you? Yes, maybe they were saying “well you deserve it” you know because they cops over there didn’t like me so I don’t think they would try to putting him in jail, they were just ignoring me.
CHAPTER 5
DISCUSSION

This study examines the social determinants of health affecting the levels of depression, stress, and self-care behaviors of a sample of HIV-infected Latino men who have sex with men on the U.S.-Mexico Border through a phenomenological approach to their lived experiences. To this researcher’s knowledge, this dissertation is the first in the region focused on these factors among this sample group, as well as the first study using such a qualitative research approach.

The interdisciplinary nature of this study is reflected in the various theoretical frameworks utilized to examine the phenomenon, from the exploration of factors on an individual level, such as mental and physical health status and individual healthcare needs, to broader socio-ecological factors, such as cultural belief and practices, social support, stigma, and other demographic factors affecting health.

The study findings provide important and relevant information about the HIV/AIDS-infected MSM population from the region, which will not only be useful to public health and mental health professionals and researchers, but also to health professionals working in clinical settings such as nursing, occupational therapy, medicine, nutrition, among others.

5.1 Mental Health

The analysis of the mental health theme elicited valuable information about the emotional state of the participants. For example, most participants in this dissertation study had been living with HIV and taking ARV medications for several years, during which time all participants dealt
with clinical depression at some point, and the overwhelming majority (with the exception of one) were still struggling with depression despite constant efforts to overcome it.

Depression not only impacted the participants’ individual mental wellbeing, but also affected other spheres of their lives. Many participants reported isolation, loss of employment, lack of interest in activities, and loss of relationships due to their depression. In addition, several participants reported having suicidal thoughts and self-harm behaviors attributed in part to the experienced levels of depression.

The majority of the participants from this study reported having from mild to severe depression, but only 30% of the total sample was being treated for it. Only 7.5% of the participants who reported severe depression had been referred to a mental health specialist or were being treated with antidepressants. There is an important gap in the management and treatment of depression among the participant sample, and this could be a possible reason why participants have been struggling with depression for such an extended period of time.

Research has shown that depression is an important mental health issue for the population examined in this study. Basta and associates (2008) as well as Feldman et al. (2012) reported that depression was the most common co-morbidity among the PLWHA. Those finding are consistent with the results of this dissertation study, which showed that all participants reported having a certain level of depression.

It has been well documented that depression plays an important role in self-care behaviors. For example Sternhell and Corr (2002) found in their study about psychiatric morbidity and adherence to ARV medication that depression was directly associated to poor ARV adherence among PLWHA. This dissertation research found that participants in the study
reported delayed ARV treatment or lapses in such treatment as a consequence of their depression.

This dissertation study findings were also consistent with previous studies about disparities in the diagnosis of depression among Latinos living with HIV/AIDS. For example, in a study conducted by Hooshyar and associates (2010) about treatment and diagnosis of depression in primary care showed that Latino PLWHA were under-diagnosed and under-treated for depression or received delayed treatment services compared to non-Latino white PLWHA. This dissertation study was only focused on Latino PLWHA so we cannot formulate any inference about non-Latino white PLWHA in the region; it is possible that non-Latino white PLWHA receive equally inadequate treatment for depression in the region.

Using both qualitative and quantitative measures for depression in this study was an important methodological approach to better understanding the role that depression plays among Latino men living on the U.S.-Mexico border. The interviews provided important information about how depression affects the participants’ lives across different spheres of the socio-ecological model, as well as in their personal self-care behaviors. On the other hand, the BDI-II validated the participant’s statements of depression and provided standardized information about the intensity of the depression symptoms and their respective classification.

Stress was a common factor affecting the wellbeing of participants in this study. The majority of the participants reported having a considerable amount of stress in their daily life, which affected the individual sphere of the ecological model. Living with HIV/AIDS was already an important stress generator among the participants of this study, and the effects of stress in mental health have also been documented in studies conducted by Wood, Shabb, Steenhoff, & Rutstein (2009) and by a study conducted by Wohl and associates (2010) focused
on the effects of stress and social support in the management of HIV. Wohl and associates established that PLWHA were able to manage their stress and HIV condition if they perceived social support from others.

The primary factors contributing to the increase of stress among the participants were changes in their physical health, vulnerability to becoming ill, the perceived difficulties in having a romantic relationship, and the perceived lack of support from partners, family and friends.

A variety of social determinants of health were identified as affecting the well-being of participants, but the ones reported to directly increase the stress levels of the participants were economic status, employment, access to and cost of primary healthcare services and medications, border violence, and state funding to HIV/AIDS programs. These factors were also described as a source of stress among Latino MSM at risk for HIV/AIDS in a qualitative Grounded Theory study conducted by De Santis, Gonzalez-Guarda, Provencio-Vasquez, and Deleon (2013).

5.1.1 Coping Strategies among Participants

Different strategies and coping styles were identified among the participants in this study to decrease the levels of stress produced by their situations and daily life activities. The primary cognitive or relaxation strategies utilized by the sample group in this study were listening to music, spiritual meditation or prayer, going to a therapist, and reading. The primary physical activities utilized to manage stress by the participants were walking and exercising.

Similarly to these findings, Martinez, Lemos, Hosek, & Adolescent Medical Trials Network (2012) published a qualitative study focused on stress coping mechanisms of Latino Adolescents living with HIV/AIDS, which describe how spirituality and physical activity were some of the stress-coping mechanisms most employed by HIV-positive Latino adolescents.
Following Lazarus and Folkman transactional model of stress and coping (1966, 1984), the majority of the participants in this dissertation research utilized an emotion-focused coping mechanism. Some of the situations, in which participants utilized emotion-focused coping were the stress caused by living with HIV/AIDS, the body changes due to the medication regimes, and the border violence.

Lazarus and Folkman (1984) stated that this type of coping mechanism is commonly used when the stressor cannot be changed. This is the case for PLWHA; they can implement different strategies to change the way that living with HIV/AIDS affects the mental health but the stimulus (living with HIV/AIDS) that is causing the distress will still be present.

Findings in this dissertation research also show that some participants also utilized problem-focused coping in situations in which participants could change the event causing stress; for example, many participants reported exercising to relax after stressful events. They also utilized physical activity to improve health conditions that caused them considerable amounts of stress.

The construct of appraisal from the transactional model of stress and coping can also be analyzed in this study and in both coping styles. Many of the coping strategies that participants used to decrease their stress levels provided them the space and time to evaluate the situation and attempt to devise solutions. At times this re-evaluation of the stressful event led to a decrease in stress and/or a decrease in the impact that the stressor had in the participants of this study.

5.2 Health Beliefs and Practices on the Border

The health beliefs and health practices of the participants in this study contributed to the ways that they sought healthcare and treatment for ARV medication side effects and
opportunistic infections. The most common belief at the individual level was of being more vulnerable to infections and illness; participants also believed that all ARV medication caused lipodystrophy and sexual dysfunction.

Some of the social determinants that participants believed interfered with their access to healthcare services were denial of HIV-infection, fear about disclosure and confidentiality of records, migratory status and lack of education and knowledge about HIV/AIDS.

Participants’ health beliefs also played an important role in the mental health of the participants. Health beliefs were primarily driven by culture and stigma in this sample. Health beliefs about body changes, sex life, and substance use were some of the most common ones reported to affect health among the interviewed Latino-PLHWA. Those health beliefs have also been described in studies conducted by VanDevanter and associates (2011) who found that young LMSMLHA believed that their sexual life and partner intimacy was dramatically affected by HIV/AIDS. The pre-conception that ARV medication produces body changes was also an important belief in that study that affected the mental care and healthcare decision making.

Latino culture and stigma were also important factors contributing to the discrimination experienced by the interviewed group. Stigma is a predominant factor that can increase the chances of stress and depression by Latino PLWHA. Kowaleski (1988) found that cultural factors such as machismo as well as the multiple types of stigma with which this group struggles (mental health, HIV/AIDS, ethnicity, and same-sex sexual behaviors) affect how differently this population implements their coping strategies, healthcare-seeking behaviors, and the quality of healthcare they received by their providers. In this dissertation research, many participants reported breaking up with their partners, losing their jobs, family separations, and receiving poor healthcare due to stigma. Latino culture is family oriented and most social support and is based
on family relationships. A study conducted by Martin and associates (2012) state that many people living with HIV/AIDS have poor coping mechanisms due to the disintegration of familial relationships generating depression and suicidal ideations (Courtenay-Quirk et al., 2006).

Participants’ health practices were also driven by culture and individual health beliefs. One of the most common health practices found in this dissertation research was to be more involved in spiritual or faith-based activities. Participants reported that these strategies kept them in a good state of mind and health. This finding dovetails with the study by Park and Nachmar (2010), which reported that faith-based activities not only promoted social support but also improved adherence to ARV treatment.

Changes in diet and exercise were also common health practices among this group. Many participants reported decreasing their intake of carbohydrates and fats and exercising more often to counterbalance the ARV treatment side effects. Participants reported including in their diet and exercise routine different types of complementary and alternative practices, such as the consumption of herbal remedies, which is a health practice embedded in traditional Mexican customs. The use of meditation and spirituality was also incorporated in the participants’ physical activity routines.

The available literature shows mixed results of the uses of complementary and alternative medicines (CAM) by PLWHA. A study conducted by Ernewall, Zea, Reisen, & Poppen (2005) shows an association between the uses of CAM and poor adherence to ARV medication and medical appointments. In this dissertation study there was no direct linkage between the use of CAM and poor adherence to HIV/AIDS healthcare regimes. One possible reason may be that CAM practices in the region are well accepted by the culture of the U.S.-Mexico border region,
and so these are not seen as alternative treatment practices specifically for HIV/AIDS, but rather as practices with broader health benefits.

Crossing the border was one of the most common health practices among the study participants. Most of the participants reported crossing the border to receive complementary healthcare, primarily to obtain access to treatments not available in the U.S. or to access more affordable or more prompt treatment available on the Mexican side of the border.

Some of the most common healthcare services PLWHA obtain on the Mexican side of the border were physician and dentist appointments, the purchase of antibiotics at affordable prices, and the procurement of herbal supplements to treat their ARV medication side effects and other conditions. In addition, many of the participants’ families, friends, and social circles were distributed between both sides of the border, and so participants reported visiting family members and friends on the Mexican side of the border.

Because of the increased border violence in recent years, many participants dramatically reduced the frequency of their visits to the Mexican side of the border due to fear of being victimized or due to the increased crossing times at the border, particularly upon re-entry into the United States. Many participants reported spending hours in line to return to the U.S. due to increased border security at crossing points, which generated stress among participants about not being able to return for their scheduled ARV dosages. Some participants who crossed the border to receive complementary healthcare also reported not taking their medications across the border because of the belief that PLWHA were still prohibited from entering into the U.S. The border violence and increased security measures thus dramatically impacted the access to complementary healthcare and the social support that participants previously had had, and this may be a contributing factor to increased levels of stress and depression among participants.
Regarding sexual practices and substance use, the participants in this study showed a reduction of substance use and strict condom use during sexual practices. Some participants with sero-discordant partners refused to engage in sexual behaviors with their partners (even with the use condom) for fear of infecting them with HIV. Also, some participants reduced their sexual activity as well ending relationships due to the risk of transmitting the HIV infection to their partners. This pattern was also found in a study conducted by VanDevanter and associates (2011) exploring substance use, psycho-social factors, and partner characteristics young Latino MSM living with HIV.

5.3 Border Violence and Social Support

Border violence was the social determinant that appeared across all four main themes. It did not only affect the ways in which participants had access to complementary healthcare, but was also a cause of the loss of or reduction in social support from family members and friends who lived on the Mexican side of the border. This impacted their ability to socialize, reduced their social support networks, and resulted in negative mental health outcomes. Most of the participants in this dissertation study reported having support primarily from their family, followed by friends. Support from partners was mixed between no support and support from the participants reporting having a partner at the time of the interview, but almost all participants reported experiencing intimate partner violence from a former or current partner.

Results in this dissertation research were consistent with studies conducted by De Santis and associates (2012, 2013), in which the role of intimate partner violence among Latino MSM was predominant and linked to other health risks. On the other hand, this dissertation study also shows unique features that this specific group utilizes to maintain their health, such is the case of
the cross-border complementary healthcare and the common use of complementary and alternative medicine.

The literature shows friends are the primary source of support among PLWHA (Zea, Reisen, Poppen, Bianchi, & Echeverry, 2005). An important finding in this dissertation study was that the primary source of support for this group was the participants’ families. One reason may be that participants in this region are closer geographically speaking to family members compared to participants in other studies, who may have emigrated from other states or countries with no available family members in close proximity.

Available research has found an important link between disclosure and support and the role they play in the retention of HIV healthcare (Zea et al., 2005; Wohl et al; 2011). The more a person discloses their HIV status to others, the more sources of support that person will receive, leading to uninterrupted HIV care. The concern is that in stigmatized cultures such as Hispanic/Latino PLWHA, participants have more difficulties in disclosing their HIV status to others, and this affects their healthcare in general. For the participants in this dissertation study, that was not the case. Almost all participants reported to being compliant with their healthcare and not missing their medical appointments and ARV treatments. Even though participants disclosed their HIV status to family, friends, and partners, only family was found to be a continuous source of support; friends and partners had mixed outcomes. It is important to explore the dynamic of family support as a protective factor in this population.
5.4 Recommendations and Future Directions

This section will address future directions and recommendations in two different modalities. First clinical implications will be addressed followed by the research implications.

5.4.1 Clinical Implications

To conclude, there is an urgent need to understand the mental health needs of Latino PLWHA in the region. All participants reported struggling with depression, and a large part of the sample was not receiving any type of treatment to control it. Most of the care that PLWHA received from their healthcare providers focused on the adherence to ARV medication and physical conditions, and there is a substantial gap in screening for and treating depression and other mental health disorders.

Mental health is a very important component in the wellbeing of PLWHA, it affects daily life activities, self-care behaviors, compliance with ARV medication, employment, and interaction with the participants’ families and friends. More efforts ought to be directed towards the care of depression and stress.

There is an urgent need to increase communication between HIV/AIDS healthcare providers and their clients about the clients’ mental health. Healthcare providers need to be more aware about the clients’ environment and the factors affecting their access to healthcare, as well as to be more familiarized with the ways that this group experience stress and depression; this can facilitate prompt diagnosis and adequate treatment for this group.

Healthcare providers also need to provide sources of information and healthcare to participants so they can be better educated in terms of self-care behaviors and prevention of opportunistic infections. This is a very important because for most of the participants in this study, the physician or the healthcare provider was the only source of information and education.
about living with HIV/AIDS. Because of the strong stigma and discrimination that this group experience in their community, the access to information and health education outside their primary healthcare provider is minimal.

5.4.2 Research Implications

Future directions of this study include the development of research into other aspects of depression and stress among the LMSMLHA population in the region, including the investigation of the effectiveness of different coping mechanisms and their effect on the quality of life and levels of depression of this population. Another important area of research would focus on interventions based on problem-focused coping mechanisms and the effect they have on the mental health of this population.

Another important factor to explore is the impact that family support plays in PLWHA compared to the other sources of support, as well as to investigate if family support acts as a protective factor in the reduction of substance use and sexual risk-behaviors.

5.5. Strengths and Limitations of the Study

Purposive sampling is an important data collection strategy used to obtain a better understanding how participants experience the phenomenon (in this case living with HIV/AIDS in the U.S.-Mexico border) by recruiting individuals with different characteristics, avoiding the case of having all sample participants falling under the same demographic range, such as age group, time on treatment, and region among others.
Trustworthiness was carefully addressed in this study. The researcher does not only use one, but several different strategies to increase the level of trustworthiness in the study to assure that the results reflected the lived-experience of the participant sample.

Due to the specificity of the sample, the research findings cannot be generalizable to other populations. The participants’ sample was collected from the population attending the community-based clinic. They can experience the phenomenon differently compared to the populations attending another clinic or that live in a different area apart from the U.S.-Mexico border.
LIST OF REFERENCES


http://www.kff.org/hivaid/7029.cfm


Psychosomatic Medicine, 75(2), 103-116. doi:10.1097/PSY.0b013e3182826881;
10.1097/PSY.0b013e3182826881


APPENDIX A

INTERVIEW GUIDING QUESTIONS

Demographic Questions

Age:

Year of birth:

Place born:

Where is your partner/spouse/couple?

Years of education:

What do you do to get income?

Language proficiency:

Year and place of diagnosis:

Length of time in care:

Frequency of crossing borders for any reason?

SOCIAL ISSUES/NETWORKS

SOCIAL ACTIVITIES: [where, when, with whom, weekend activities, after work, family activities, friend’s sex, nationality, age]

How often do you go out to have fun?

When do you go out?

¿What type of places you visit when you go out?

With whom do you go out?
Your friends live in the area of:
- El Paso [ ]
- Juarez [ ]
- Las Cruces [ ]
- Other: [ ]

Generally your friends are: men [ ], women [ ], from what age, nationality?

**ACTIVITIES/FRIENDSHIPS WITH PEOPLE LIVING WITH HIV/AIDS**

Do you have friends that are living with HIV/AIDS?

Describe the activities you do with your friends: [Including the ones you do with friends living with HIV/AIDS?]

**DAILY ROUTINE**

**TYPICAL DAY:** [Probes: Work; what kind of activities do you do after work? Do you have any household responsibilities, care needs, transportation or financial issues?]

How is a typical day for you?

Can you explain me what activities you do in a regular/typical day?

What activities you do after work?

Do you have any household responsibility?

Do you need specific care?

How do you transport yourself in the city?

Do you have any economical issues?

**HOW HAS LIVING WITH HIV AFFECTED YOUR RELATIONSHIPS? DO FAMILY/PARTNERS/FRIENDS KNOW YOUR DIAGNOSIS? SUPPORT YOU? REJECT YOU?**

How can you describe your partner/spouse/ BF/GF? [Physically and emotionally]

How long have you been together?

Where did you met? Where the relationship initiated? Do you live together?

Can you describe in general your prior partner/spouse/ BF/GF [approximately how many?]

Have your relationships with partner/spouse/family/friends changed after your diagnosis?
Does your family/partner/friends/spouse know your diagnosis? Do you feel any support/rejection?

**DOMESTIC VIOLENCE/ABUSE**

Have you ever been involved in any violent/abusive relationship?

**STRESS**

*EXPLORE STRESS PERCEIVED HERE* [amount, type, causes, and ways of coping; perceived sequelae]

*IN WHAT WAYS DO THE STRESSES OF LIVING WITH HIV AFFECT YOUR LIFE?* [Probe: attitude, behavior, relationships, health, risk behaviors]

*IN WHAT WAYS DO DAILY STRESSES OF LIVING AFFECT YOUR LIVING WITH HIV?* [I.e. food & income & abuse issues take precedence over medications adherence]

Have you noticed any important emotional change since your diagnosis?

Has the interaction with other people changed since your diagnosis?

Have you notice any change in your stress level increased after your diagnosis? [Maybe we can use a likert scale to rate from 1 to 10 their stress level]

At this point what factor impacts your stress level the most in your daily activity? [I.e. Nutrition, health care, family, economy, etc.]

What do you do to decrease [lower] your stress level?

Do you feel that stress affects your daily performance? If so, in what ways?

Do you take decisions or actions that could risk your health status? [If yes ask for examples]

Have you heard that people living with HIV/AIDS feel depressed? [Can you elaborate more?]

How do people express their depression feeling?

Are you taking any depression medication? [If so, can you tell me more about it?]

*DEPRESSION SCALE (BDI-II).*
HEALTH BELIEFS AND PRACTICES

MAIN HEALTH CONCERN

WHAT IS DONE TO HELP STAY HEALTHY? (Probe: differences in behavior since infection)

PERCEIVED VULNERABILITY/SUSCEPTIBILITY TO SICKNESS, EXPLAIN.

DIFFERENCES IN DIET/NUTRITION FREQUENCY OF SICKNESS SINCE BECOMING INFECTED [Probes: type of disease, length of illness]

Are you concern about any aspect of your health?

Do you do something to stay healthy?

Has your healthcare changed since your diagnosis?

Have you change your diet since your diagnosis? [Why?]

Did you feel more vulnerable [susceptible] to get sick since your diagnosis?

Since your diagnosis, what types of illnesses have you acquired? For how long?
APPENDIX B

INFORMED CONSENT

Consent to Participate In a Research Study

The purpose of this consent form is to provide you with the information you need to consider in deciding whether to participate in this research study.

Study title:
ARV ADOPTION & ADHERENCE IN A US-MEXICO BORDER COMMUNITY-BASED CLINIC

Michele G. Shedlin, PhD, Principal Investigator

Study Purpose
You are being asked to participate in an interview on the service needs of Latinos infected with or affected by HIV, the virus that causes AIDS. This is a study taking place at La Fe, with individuals from El Paso and Juarez. The main purpose of this study is to help the providers of HIV/AIDS care to understand the many complex issues surrounding adherence to medications.

You qualify as a possible participant in this study because you are knowledgeable about the HIV infected individuals and have experience with this population.

Study Procedures
If you decide to participate, you will be asked to take part in an individual interview that should last about one hour. You will not have to give your name; you can use a false name or go without using any name, and your name or other identifying information will not be recorded by the interviewer. The topics that will be discussed have to do with your experience in the clinic and the service needs of individual with HIV. The discussion may be tape recorded so that none of the details are lost or forgotten. The interviewer and the research team will analyze the discussion. The recording and any analysis of the interview will be kept in a locked file at UTEP.

When we write a report with the results of the analysis from the interviews the information will be summarized. No information that could be identified with any individual participating in the study will be reported. You can request a copy of the final report from the La Fe staff if you would like to see it.

Study Risks
Participating in this study only involves discussion. It does not involve any medical treatment or experiment. It is possible that a participant could feel distress from discussion of service needs. We recognize that you are concerned about confidentiality. You will not be asked to give or sign your name so as to minimize threats to your confidentiality.
Study Benefits
You are not expected to benefit personally from this study. It is possible that other healthcare providers will benefit from there having been a discussion of their service needs considered when planning and assessing services.

Alternatives
You have the option to not participate in this study. Deciding not to participate will not cause any penalties.

Costs
There are no costs to you for participation in this study.

Compensation
No monetary compensation will be provided for participating in the study.

Confidentiality
You are not required to give your name or any other identifying information. Any information obtained during this study which could be identified with you will remain confidential. Recording, transcripts, and the analysis will be kept in a locked office at La Fe or in locked files in the office of Dr. Shedlin. Only research staff from UTEP will have access to these materials. The summary report on the study will not identify any individual participant by name.

Participation is Voluntary
Your participation in this study is completely voluntary. You can refuse to participate, or withdraw from the study at any time, this will not cause any penalty, Signing this form does not waive any of your legal rights.

Questions
If you have any questions, please ask, and we will do our best to answer them. If you have additional questions in the future, you can reach Dr. Michele Shedlin at (917) 834-4941 or Dr. Jose Rivera at 747-8535. If you have any questions on your rights as a research subject, you can call Annabelle Casas at the UTEP Institutional Review Board at 915-747-8841 for information.

Statement of Consent
I have discussed this study with ____________________ to my satisfaction. I understand that my participation is voluntary and that I can withdraw from the study at any time without prejudice. I have read the above and agree to enter this research study. Signing this form does not waive any of my legal rights.

Signatures:
Participant _______________________________ Date ______________________

Investigator Eliciting Consent ___________________________________________
Consentimiento para Participar en Estudios de Investigación

El propósito de esta forma de consentimiento es brindarle a usted la información que necesita para saber tomar la decisión de participar en esta investigación.

<table>
<thead>
<tr>
<th>Titulo del estudio:</th>
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<tbody>
<tr>
<td>SELECCIÓN Y ADHERENCIA DEL USO DE ANTIRETROVIRALES EN UNA CLÍNICA COMUNITARIA EN LA FRONTERA EUA-MÉXICO</td>
</tr>
<tr>
<td>Michele G. Shedlin, PhD, Investigadora Principal</td>
</tr>
</tbody>
</table>

Propósito del Estudio
Se le pide que participe en una entrevista acerca de las necesidades de servicios en los Latinos infectados o afectados por el VIH, el virus que causa el SIDA. Este estudio se realiza aquí en la clínica La Fe, con individuos de El Paso y Cuidad Juárez. El propósito principal de este estudio es ayudar a los proveedores de cuidado de VIH/SIDA, a entender la variedad de problemas complejos que rodean la adherencia a la medicina.

Usted califica como posible candidato para éste estudio porque usted es de esta área y ha sido diagnosticado con VIH o SIDA y a su vez asiste a esta clínica. Su proveedor clínico lo ha invitado a participar porque usted cumple con los requisitos.

Procedimientos del Estudio
Si decide participar, se le pedirá tomar parte en una entrevista individual que tendrá una duración de una hora ó una entrevista en grupo que tendrá una duración de una hora y media (1.5 hr). No será necesario dar su nombre, puede usar un nombre falso si gusta, ó no usar ningún nombre. Cualquier otra información que pueda identificarlo no será registrada por el entrevistador. Los temas de la discusión se enfocarán en su experiencia en la clínica y el uso de medicamentos. La discusión será grabada para que ningún detalle de la entrevista sea olvidado o perdido. El entrevistador y el equipo de investigación analizarán la grabación, y cualquier análisis de esta será puesto bajo llave en La Fe, o en la oficina de la Dra. Shedlin.

Al escribir el reporte del análisis de las entrevistas, se presentará en forma resumida para que ninguna información se pueda relacionar con algún paciente. Puede pedir una copia del reporte final en la clínica La Fé, si así lo desea.

Riesgos del Estudio
La participación en este estudio, solo requiere formar parte de una entrevista. No requiere de ninguno tipo de tratamiento médico o de un experimento. Es posible que el individuo sienta algo de incomodidad al hablar sobre los problemas de salud. Nosotros sabemos que mucha gente que es infectada ó afectada por el VIH, se preocupa que su identidad se mantenga confidencial por lo que no se le pedirá que proporcione su nombre para así mantener su identidad confidencial.

Beneficios del Estudio
No se espera que usted sea beneficiado directamente. Es posible que otros con VIH/SIDA sean beneficiados de esta entrevista cuando se realice la evaluación y planeación de las necesidades de servicios.
Alternativas
Tiene la opción de no tomar parte en este estudio. El decidir no formar parte de este estudio, no afectara el cuidado que se le brinda en La Fe ó en cualquier otro lugar.

Costos
No hay ningún costo por participar en este estudio.

Compensación
Por participar en este estudio usted recibirá $30.00 (treinta dólares), al final de la entrevista.

Confidencialidad
No se requiere dar el nombre o ningún tipo de identificación. Cualquier información recabada durante el estudio será confidencial. grabaciones, textos, y análisis serán guardados bajo llave en La Fe o por la Dra. Shedlin. Únicamente el personal de investigación de UTEP, tendrá acceso a esta información. El reporte final no identificara a ningún paciente o miembro de la familia por su nombre.

La Participación será Voluntaria
Su participación en este estudio es completamente voluntaria. Usted puede retirarse del estudio en cualquier momento, su decisión no afectara tu atención médica en la clínica La Fe ahora, ó en el futuro. El firmar el documento no interfiere con ninguno de sus derechos legales.

Preguntas
Si usted tiene cualquier pregunta, por favor háganoslo saber, y nosotros haremos lo posible para contestar y aclarar todas sus dudas. Cualquier duda que surja en el futuro, puede comunicarse con la Dra. Michele Shedlin al teléfono (917) 834-4941 o con el Dr. José Rivera al teléfono (915) 747-8535. Si usted tiene cualquier duda sobre sus derechos como participante de la investigación, puede comunicarse con Lola Norton del Institucional Review Board en UTEP al teléfono (915)747-8841.

Declaración del Consentimiento
Yo he discutido sobre este estudio con _____________________ hasta despejar todas mis dudas. Yo entiendo que mi participación en este estudio es voluntaria y que puedo retirarme en cualquier momento sin ningún tipo de prejuicio. He leído y comprendido, aceptando los términos del estudio. Firmar este documento no interfiere con ninguno de mis derechos legales.

Firmas:

Participante: ________________________________ Fecha: ________________

Investigador que adquiere consentimiento: ____________________________________________

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## APPENDIX C

### LIST OF CODES

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<td>(B) HIV</td>
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<td>Social Services</td>
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<td>Substance Use</td>
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APPENDIX D

EXAMPLES OF ATLAS.TI QUERY TOOL AND QUOTATION TOOL OUTPUTS

a) Excerpt Output of Quotation Tool:

List of current quotations (1,828). Quotation-Filter: All (Extended version)

HU: Dissertation HU
File: [C:\Users\obeltran\Desktop\Total Transcriptions\Documents\Dissertation HU.hpr7]
Edited by: obeltran
Date/Time: 2013-10-29 12:11:07

1:1 How many times do you cross th.. (27:37)
1:2 Do you have any type of insura.. (79:81)
1:3 Anything else that they have g.. (127:129)
1:4 but like for sore throat, or t.. (129:129)
1:5 The first thing we wanted to t.. (143:165)
1:6 Do you have friends that are l.. (171:173)
1:7 But nobody that you would cons.. (175:177)
1:8 Juarez now, we stopped going o.. (177:177)
1:9 I had a friend, who was a real.. (177:177)
1:10 What was more important in thi.. (179:181)
1:11 Did you become more concern wi.. (183:185)
1:12 Lately it's been a little slow.. (189:189)
1:13 Do you have any particular eco.. (195:197)
1:14 fortunately I live with my par.. (197:197)
1:15 .Yes, but I wouldn't say it is.. (217:217)
1:16 So I don't know if it is consi.. (217:217)
1:17 The next issue is stress, whic.. (223:225)
1:18 And related to that could be p.. (225:227)
1:19 Yes, it changed, it definitely.. (235:235)
1:20 If you have to put your stress.. (237:239)
1:21 And is there anything special .. (245:247)
1:22 Obviously HIV and...uhmmm...wh.. (261:261)
1:23 You know what I am thinking wh.. (269:269)
a) Excerpt Output of Query Tool:

Query Report

HU: Dissertation HU
File: [C:\Users\obeltran\Desktop\Total Transcriptions\Documents\Dissertation HU.hpr7]
Edited by: obeltran
Date/Time: 2013-10-29 12:13:50

7 Quotations found for query:
"Depression"
Clipped quotation content to number of characters: full length

And right now beside this treatment are you taking any other type of medications?

- Antidepressants [Any other?] No.

I'm depressed and of course, right now I’m not interested. It’s the last thing I have in my mind but depression made me lose interest.

yo pase un, un trago muy amargo con lo que te platicaba de eso, que te diagnostican esto, que te diagnostican lo otro, entonces yo pase, yo sufri mucho pa’ que me entiendas en ese momento, ese año, ese 2006 fue muy dificil pa’ mi, me deprimia por cualquier cosa, estaba muy mal, si sabes como, entonces yo vea a alguien que esta asi me preocupa, porque yo se, yo pase por eso,

traía muchas de esas depresiones, traía mucho, muchas ansiedades, depresiones y muchos problemas y muchas cosas y que voy a hacer, y que quien sabe que, imagínate
  <ref>P22: 032XM.docx - 22:46 (335:335) by Super</ref>

Ya después de que empezó, no al principio, claro que no, entonces yo lloro mucho, me deprimí mucho
  <ref>P22: 032XM.docx - 22:50 (337:337) by Super</ref>
APPENDIX E
THEMES AND SUBCATEGORIES

Mental Health
- Depression
- Stress
- Stress Coping
- Suicidal Thoughts

Health Beliefs
- HIV/AIDS Beliefs
- ARV Tx. Beliefs
- Barriers to Healthcare
- HIV/AIDS Education
- Stigma
APPENDIX F

CONCEPTUAL FRAMEWORK
CURRICULUM VITAE

Oscar Beltran

Interdisciplinary Health Sciences

Dr. Oscar Beltran earned his Bachelors of Science in Psychology from the Universidad Autonoma de Cd. Juarez in 2004. Oscar received his Master of Sciences in Health Promotion and Education in 2008 from the University of Texas at El Paso, and in the fall of 2008, Oscar joined the doctoral program in Interdisciplinary Health Sciences at the University of Texas at El Paso.

Dr. Beltran has been the recipient of numerous honors and awards including the TIES binational-Fellowship focused in conducting tuberculosis research on the U.S. - Mexico Border. He was also a recipient of the Fenway Institute Center for Population Research Pre-doctoral Training Fellowship focused on LGBT health research, and given multiple travel awards to present his research national and international renowned conferences.

While pursuing his degree, Dr. Beltran worked as a research associate for the College of Health Sciences and School of Nursing, as well as a teaching assistant for the Women’s and Gender Studies Program. Due to his interdisciplinary background, Dr. Beltran has collaborated in different federally funded research projects focused on HIV/AIDS and other chronic and infectious conditions, which has resulted in articles published on peer-reviewed journals such as the Journal of Immigrant Minority Health, the Journal of the Association of Nurses in AIDS Care, and the Journal of Pediatric Nursing. He has also collaborated with faculty from other departments at the University of Texas at El Paso as well as with other academic institutions in the U.S.
Dr. Beltran’s dissertation research is entitled *Social Determinants Affecting the Mental Health of HIV-Infected Latino Men who have Sex with Men on the U.S. – Mexico Border*, supervised by Dr. Elias Provencio-Vasquez. Recently Dr. Beltran has accepted a postdoctoral position at the Centers for Disease Control and Prevention (CDC).